Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04001

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Roger Joseph Lerwill
2. Date of Death (Month, Day, Year): January 28, 2001
3. Time of Death: 8:45 P.M.

4a. Facility Name (If not institution, give street and number): 509 Hall Court
4b. City, Town, or Location of Death: Havre de Grace
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 516-26-6147
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar. 23, 1927
9. Birthplace (State or Foreign Country): Utah

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Havre de Grace
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 509 Hall Court
10f. Zip Code: 21078
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1945-46
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chief Safety Engineer
16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): Joseph R. Lerwill
18. Mother's Name (First, Middle, Maiden Surname): Ruth Walker

19a. Informant's Name/Relationship (Type, Print): Julia G. Corso (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 509 Hall Ct., Havre de Grace, Maryland 21078

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery
Date: 1/31/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Kenneth B. Cargo
22. Name and Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CONGESTIVE HEART FAILURE — 6 MONTHS

Due to (or as a consequence of):
b. ISCHEMIC HEART DISEASE

Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was cese referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Andrew Nowakowski MD
29c. License number: D08096
29d. Date signed (Month, Dey, Year): JANUARY 29, 2001

30. Name end eddress of person who completed ceuse of death (Item 23a) (Type, Print): ANDREW NOWAKOWSKI MD 125 N. MAIN ST. BEL AIR, MD. 21014

State Registrar

31. Date filed (Month, Dey, Year): JAN 31 2001
32. Registrar's Signature: ▶ [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificete be executed within 24 hours after deeth.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04002

Cal Pellitteri

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Dete of Deeth Month / Dey / Yeer	3. Time of Deeth
CAL	J.	PELLITTERI	January 30, 2001	0645

4a. Facility Name (If not institution, give street end number)	4b. City, Town, or Location of Death	4c. County of Deeth
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Deys	If Under 24 Hrs.: Hours / Min.	8. Dete of Birth (Month, Dey, Year)	9. Birthplece (Stete or Foreign Country)
112-05-9587	1☒ M 2☐ F	83 Yrs.			May 13,1917	New York

Usuel Residence of Decedent

10a. Stete	10b. County	10c. City, Town or Location	10d. Inside City Limits
New York	Nassau	Hempstead	1☒ Yes 2☐ No

10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
565 Decator Street	11550	USA

11. Meritel Stetus	12. Wes Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Bleck, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Detes:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Eduction (Specify only highest grade completed)		16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
12	-	Electrician	Nassau County

17. Father's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
Antonio Pellitteri	Angelina (unknown)

19a. Informent's Name/Reletionship (Type, Print)	19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
Angela Leonard/Daughter	772 Hemp Blvd., Uniondale, NY 11553

20e. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, Stete
1☒ Burial 2☐ Cremation 3☐ Remoyal from Stete 4☐ Donetion 5☐ Other (Specify)	Pinelawn Memorial Park Cemetery	2/3/01	Pinelawn, NY

21. Signeture of Funeral Service Licensee	22. Neme end Addrass of Facility
▶ Keith R Devey CFSP	Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet ceused tha daath. Do not enter the moda of dying, such es cerdiec or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediate Cause (Final diseese or condition resulting in deeth) — e. Bladder cancer

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immadiate ceuse. Entar Underlying Cause (Diseese or injury thet initieted events resulting in death) Lest

b. ASCVD

Dua to (or es e consequence of):

c.

Dua to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed?	24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was cese referred to medical examiner?	26. Place of Deeth (Check only one)	
1☐ Yes 2☒ No	Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner es stated.
2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶ NATESAN	D 47094	1/30/01

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)
NATESAN 106 PINE BLUFF ROAD SALISBURY MD 21801

3 PQ

State Registrar

31. Dete filed (Month, Dey, Year)	32. Registrar's Signatura
JAN 30 2001	▶ Geneva G Sparks

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that tha deeth certificate be executed within 24 hours after deeth.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04003

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George Clay Rutherford, Jr.

2. Data of Death: Month JANUARY Day 29, Year 2001

3. Time of Death: 3:00 AM

4a. Facility Name (If not institution, give street and number): 1111 Hanson Road Nickols Senior Care

4b. City, Town, or Location of Death: Edgewood

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 219-28-4980

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Jan. 7, 1933

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1316 Conowingo Road

10f. Zip Code: 21014

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner/Operator

18b. Kind of Business/Industry: Hauling

17. Father's Name (First, Middle, Last): George Clay Rutherford, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Hannah Juniata Jones

19a. Informant's Name/Relationship (Type, Print): Margarette L. Rutherford/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1316 Conowingo Road, Bel Air, MD 21014

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Bel Air Memorial Gardens

Date: 2/1/01

20c. Location - City or Town, State: Bel Air, MD

21. Signature of Funeral Service Licensee: Stephen A. Neugebauer

22. Name and Address of Facility: McComas Funeral Home, P.A. 50 West Broadway Street, Bel Air, MD 21014

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. CARCINOMA, LUNG — 6 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CEREBRAL VASCULAR ACCIDENT

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A. Nowakowski MD

29c. License number: D08096

29d. Date signed (Month, Day, Year): JANUARY 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A. NOWAKOWSKI MD 125 N. MAIN ST. BEL AIR, MD 21014

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001

32. Registrar's Signature: D. [illegible]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

JM

10+1

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[illegible]

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01084

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Bernard J. Sanzone

2. Date of Death Month Day Year: January 29, 2001

3. Time of Death: 12:36 AM

4a. Facility Name *(If not institution, give street and number)*: 7 Raylon Drive, Apt. A

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-14-0141

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 23, 1925

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 7 Raylon Drive, Apt. A

10f. Zip Code: 21236

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Deputy Police Officer/Sheriff

16b. Kind of Business/Industry: Baltimore City Police Dept.

17. Father's Name *(First, Middle, Last)*: Vincent Sanzone

18. Mother's Name *(First, Middle, Maiden Surname)*: Grace Tuminello

19a. Informant's Name/Reletionship *(Type, Print)*: Mrs. Mary Lesser (daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9033 Scotts Haven Dr., Baltimore, MD 21234

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gardens of Faith Cemetery

Date: 2/01/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Brian A. Willem

22. Name end Address of Fecility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final diseese or condition resulting in deeth)

a. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, dete end piece, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Schendel

29c. License number: D39758

29d. Date signed *(Month, Day, Year)*: 1-29-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kevin Schendel MD 9101 Franklin Sq. Drive, Suite 321, Balto., MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 31 2001

32. Registrar's Signeture: B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04005

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Virginia Katherine Stoos

2. Data of Death Month Dey Year: January 24, 2001

3. Tima of Death: 7:00 pm

4e Facility Neme (If not institution, give street end number): Dorchester General Hospital

4b. City, Town, or Location of Deeth: Cambridge

4c. County of Deeth: Dorchester

Funeral Director

5. Social Security Number: 199-24-6537

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. lest birthdey): 84 Yrs.

If Under 1 Yaar: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): March 26, 1916

9. Birthpleca (Stete or Foreign Country): Pennsylvania

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: Dorchester

10c. City, Town or Location: Taylors Island

10d. Insida City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 4427 Bay Shore Road

10f. Zip Code: 21669

10g. Citizen of Whet Country?: USA

11. Marital Stetus: 1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Yaer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed)

Elementery/Secondery (0-12): 6

College (1-4or 5+):

16e. Decedent's Usuel Occupetion (Give kind of work done duning most of working life. DO NOT use retired): Cleaner

16b. Kind of Business/Industry: Bus Transportation

17. Fether's Neme (First, Middle, Last): William Burkey

18. Mother's Name (First, Middle, Maiden Surneme): Erma France

19a. Informent's Name/Relationship (Type, Print): Ronald J. Stoos/Son

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): P.O. Box 32, Taylors Island, MD 21669

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): BethlehemChurchCemetery

Date: 1-27-01

20c. Location - City or Town, Stete: Taylors Island, MD

21. Signeture of Funeral Service Licensee: Curran-Bromwell

22. Name and Address of Feciility: Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heert failure. List only one ceuse on eech line.

Approximate Interval Between Onset end Death

Immediate Ceuse (Final diseese or condition resulting in deeth)

e. Sepsis — Two weeks

Due to (or as e consequence of):

b. Aspiration Pneumonia — Two weeks

Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last

Due to (or es a consequence of):

c.

Due to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yss 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy parformed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes casa referred to medicel axaminer? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end place, end due to the cause(s) end menner steted.

29b. Signetura and title of certifier: MD

29c. License number: D 47924

29d. Data signed (Month, Day, Year): 1-26-01

30. Neme end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print): NOMAN TITANWY 300 AURORA STREET CAMBRIDGE MD 21613

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 29 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04006

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: JAMES SAMUEL WELCH
2. Date of Deeth Month / Day / Yaar: Jan. 30, 2001
3. Tima of Death: 3:40pm
4a Facility Nama *(If not institution, giva street and number)*: Civista Medical Center
4b. City, Town, or Location of Daath: La Plata
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 212-16-4091
6. Sax: 1 [X] M 2 [ ] F
7. Aga *(In yrs. last birthday)*: 81 Yrs. — If Undar 1 Yaar: Months / Days — If Undar 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Yaar)*: June 28, 1919
9. Birthplaca *(Stata or Foreign Country)*: Maryland

Usual Raaidence of Decedant

10a. Stata: Maryland
10b. County: Charles
10c. City, Town or Location: Indian Head
10d. Insida City Limits: 1 [ ] Yas 2 [X] No
10e. Street and Number: Chapmans Landing Road
10f. Zip Coda: 20640
10g. Citizan of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Evar in U.S. Armad Forcas? 1 [ ] Yas 2 [X] No — If Yas, Giva Yaar or Datas:
13. Was Decedant of Hispanic Orlgin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - Amarican Indian, Black, Whita, etc. *Specify:* White

15. Decedant's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 — Collega (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use retired)*: Laborer
16b. Kind of Business/Industry: US Federal Government

17. Fether's Neme *(First, Middla, Last)*: Tilton Rudolph Welch
18. Mothar's Nama *(First, Middle, Maiden Sumama)*: Mary D. Mattingly

19a. Informant's Neme/Ralationship *(Type, Print)*: Vincent R. Welch-Brother
19b. Malling Address *(Straet end Number or Rural Routa Number, City or Town, State, Zip Coda)*: 104 East Chatham St., Fredericksburg, VA 22405

20a. Mathod of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Othar *(Specify)*
20b. Place of Disposition *(Nama of cemetery, crematory or othar placa)*: Huntt Crematory
Data: 2-1-01
20c. Location - City or Town, State: Waldorf, Maryland

21. Signatura of Funeral Service Licensee: Mark G. Brohawn M00053
22. Nama and Addrass of Faciity: Huntt Funeral Home, Inc. P. O. Box 156, Waldorf, MD 20604

Physician /Medical Examiner

23a. Part I. Entar tha diseasa, or complicetions thet causad tha daath. Do not anter the mode of dying, such as cardiac or raspiratory errast, shock, or haart failura. List only one ceuse on eech line.

Approximata Interval Batween Onset end Death

Immediate Cause (Final disaase or condition resulting in deeth): a. Cardiac Arrest
Dua to (or as a consequance of): b. Myocardial Infarct
Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Ceuse (Diseesa or injury that initiated evants resulting in death) Last: Due to (or as a consequance of): c. Hypertension
Dua to (or as a consequance of): d.

Part II. **Other significant conditions** contributing to daath but not resulting in tha underlying cause given in Part I.: Parkinson's disease.

23b. Did tobacco use contribute to the cauee of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performad? 1 [ ] Yas 2 [X] No
24b. Wara autopsy findings availabla prior to completion of causa of death? 1 [ ] Yas 2 [ ] No

25. Was casa rafarred to madical axaminar? 1 [ ] Yas 2 [X] No
26. Placa of Death *(Chack only ona)*: Hospital: 1 [X] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Homa 5 [ ] Rasidance 6 [ ] Othar *(Specify)*

27. Mannar of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Panding Investigetion 6 [ ] Could not be determined
28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury M
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Dascribe how injury occurred
28a. Place of Injury - At home, farm, straat, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1 [X] **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and place, end dua to the cause(s) end manner as stated. 2 [ ] **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, death occurred at the time, dete end place, and due to tha causa(s) and mannar statad.

29b. Signatura and Tila of cartifiar:
29c. Licansa number: D-46979
29d. Date signed *(Month, Day, Yaar)*: 1/31/01

30. Nama and eddrass of person who complated causa of daath (Item 23e) (Type, Print): Collins P. Sein,MD, 605 East Charles Street, La Plata, Maryland 20646

State Registrar

31. Data filed *(Month, Day, Yaar)*: FEB 02 2001
32. Ragistrar's Signatura: Benna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

James S. Welch

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04007

Joseph E Wills

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Edward Wills
2. Date of Death (Month, Day, Year): January 30, 2001
3. Time of Death: 2:44 AM
4a. Facility Name (If not institution, give street and number): Civista Medical Center
4b. City, Town, or Location of Death: LaPlata
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 214-42-1589
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 59 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11-13-1941
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Charles
10c. City, Town or Location: Welcome
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7565 Annapolis Woods Road
10f. Zip Code: 20693
10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales Associate
16b. Kind of Business/Industry: Department Store

17. Father's Name (First, Middle, Last): Harry Wills
18. Mother's Name (First, Middle, Maiden Surname): Mary Louis Thomas

19a. Informant's Name/Relationship (Type, Print): Viola C. Warren/Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4760 Stone Hurst Drive, Woodbridge, Virginia 22192

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Charles Cemetery
Date: 02-02-2001
20c. Location - City or Town, State: Indian Head, Maryland

21. Signature of Funeral Service Licensee: [signature] M00668
22. Name and Address of Facility: Williams Funeral Home, P.A. 20640, 4270 Hawthorne Road, Indian Head, Maryland

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 26a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Renal Insufficiency
Due to (or as a consequence of): b. Diabetes Mellitus
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D-0021031
29d. Date signed (Month, Day, Year): 1/31/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Michael A. Leatherwood, MD. 12070 Old Line Center, Suite 202 Waldorf, Maryland 20602

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04008

WILLIAM HOWARD WALSTON
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM HOWARD WALSTON
2. Date of Death: Month JAN. Day 27, Year 2001
3. Time of Death: 6:00 PM
4a. Facility Name (If not institution, give street and number): SALISBURY CENTER: GENESIS ELDERCARE
4b. City, Town, or Location of Death: SALISBURY, MD
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 215-20-2339
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 27,1909
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residanca of Decedent

10a. Stete: Maryland
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 31643 Mt. Hermon Rd.
10f. Zip Code: 21804
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White
15. Decedant's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 College (1-4or 5+): –
16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use ratired): Millwright
16b. Kind of Businass/Industry: Lumber
17. Father's Neme (First, Middle, Last): Murray Walston
18. Mother's Name (First, Middle, Maidan Surname): Minnie Farlow
19a. Informant's Name/Ralationship (Type, Print): James C. Walston/Son
19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 31992 Bonhill Dr., Salisbury, MD 21804
20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parsons Cemetery
Data: 1/31/01
20c. Location - City or Town, State: Salisbury, MD
21. Signature of Funeral Service Licensee: ▶ Keith R Lowery CFSP
22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one causa on each line.

Approximate Interval Betwaan Onset and Death

Immediata Cause (Final disease or condition resulting in death)
a. CHF

Dua to (or as a consequenca of):
b. stroke about fibrillation

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequanca of):
c. arteriosclerosis
Due to (or as a consequanca of):
d. hypothyroidism

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examinar? 1☐ Yes 2☑ No
26. Place of Death (Chack only ona): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify)
27. Manrar of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)
28f. Location (Straet and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurred at the time, date and placa, and dua to the causa(s) and manner stated.

29b. Signature end title of certifier: ▶ B Neary
29c. License number: D13053
29d. Date signed (Month, Day, Year): 1/30/01

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): WILLIAM BEN HORNER, 100 POWER ST., SALISBURY, MD 21804

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

3Q

01-0641-510
crn
Christopher M Yozviak

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM 23a,b,27&28a-f per ME G/94 042561 SS

Certificate of Death

Reg. No. 2001 04009

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Dey Year	3. Time of Death
Christopher M. Yozviak	February 05, 2001	2:00 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Johns Hopkins Bayview Medical Center	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. lest birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Dete of Birth (Month, Dey, Yeer)	9. Birthplece (Stete or Foreign Country)
215-13-2965	1☐M 2☐F	15 Yrs.			April 27, 1985	Hawaii

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Harford	Abingdon	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
580 Doefield Court	21009	USA

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - Americen Indian, Bleck, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		Student	N/A

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Stephen J. Yozviak	Sheila A. Paul

19e. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Stephen J. Yozviak/Father	580 Doefield Court, Abingdon, Maryland 21009

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, State
1☒Buriel 2☐Cremation 3☐Removel from State 4☐Donation 5☐Other (Specify)	Bel Air Memorial Gardens	02-08-2001	Bel Air, Maryland

21. Signature of Funeral Service Licensee: ▶ Amanda Kelly

22. Name and Address of Facility: Schimunek Funeral Home of Bel Air, 610 W. Macphail Rd., Bel Air, Maryland 21014

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in deeth)	a. HYPOXIC-ISCHEMIC ENCEPHALOPATHY AND CEREBRAL EDEMA COMPLICATING A CARDIAC ARRHYTHMIA ASSOCIATED WITH CARDIAC RIGHT VENTRICULAR HYPERTROPHY AND SPINAL FUSION SURGERY	
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last	Due to (or as e consequence of): b. SCHEUERMANN'S KYPHOSIS	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Wes decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Dey Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnency 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probebly 4☐Unknown

24e. Was en autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical exeminer?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

Medical Certification: To Be Completed by Physician/Medical Examiner

27. Menner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☐Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined	1-30-01	5:55 P M	1☐Yes 2☒No	unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, State)
hospital	Johns Hopkins Bayview Hospital, Baltimore City, MD

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end menner as steted.
2☒ **Medical Examinar:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the ceuse(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Yeer)
▶ Stephen R Radentz MD	O.C.M.E.	February 06, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 13 2001	▶ Geneva G Sparks

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturel', or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

amend item 30 per dvr G792 2/13/01 yf
Amend#23a,25 perPhyG792 2/13/2001 EW

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04010

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Natalie Adams

2. Deta of Deeth — Month: 02 Day: 02 Year: 2001

3. Time of Death: 1920

4a Facility Name *(If not institution, give street and number)*: University of Maryland Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 220-22-0803

6. Sex: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 74 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Oct 17, 1926

9. Birthplace *(Stata or Foraign Country)*: Maryland

Usual Rasidance of Decedant

10a. Stata: MD

10b. County: Harford

10c. City, Town or Location: Havre de Grace

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 725 S. Washington Street

10f. Zip Coda: 21078

10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Nevar Merried 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Americen Indian, Black, White, atc. *Specify:* white

15. Decedent's Education *(Specify only highast grade completed)*: Elementary/Secondary (0-12): 12 / Collega (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT use retired)*: secretary

16b. Kind of Business/Industry: banking

17. Fathar's Nema *(First, Middle, Last)*: Harry M. Heisler

18. Mothar's Nama *(First, Middle, Maidan Surnama)*: Mabel Reynolds

19a. Informant's Name/Reletionship *(Type, Print)*: Cynthia Maser/daughter

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 210 Philadelphia Pike Wilmington, DE 19809

20a. Mathod of Disposition: 1☐ Burial 2☐ Cremation 3☐ Ramoval from Stata 4☒ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cematary, cramatory or othar place)*

Date

20c. Location - City or Town, Stata

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part1. Entar the disaasa, or complications that caused tha daath. Do not enter tha mode of dying, such as cardiac or raspiretory errest, shock, or heert failura. List only ona cause on each line.

Approximata Interval Batween Onsat and Daath

Immediata Causa (Final disaasa or condition rasulting in daath)

a. subdural hematoma

Dua to (or as a consequance of):

Sequentially list conditions, if any, leading to immadiata ceuse. Enter Undarlying Cause (Disease or injury that initiated events rasulting in death) Last

b. HYPERTENSION

Dua to (or as e consequence of):

c.

Dua to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying ceuse givan in Part I.

brain herniation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of cause of daath? 1☐ Yes 2☐ No

25. Was cesa rafarred to medicet examinar? 1☐ Yas 2☒ No

26. Placa of Death *(Check only one)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Homa 5☐ Rasidence 6☐ Other *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28e. Place of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledga, deeth occurred at tha time, date and plece, end due to the ceuse(s) end manner es steted. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and due to the cause(s) and mannar stated.

29b. Signatura end titla of certifiar: William Chang, MD

29c. Licensa number: AU417643SC13166

29d. Date signed *(Month, Day, Year)*: 02 02 2001

30. Nama and addrass of person who complatad cause of deeth (Item 23e) (Type, Print): William Chang M.D. University of Maryland Hospital Baltimore, Maryland 21203

State Registrar

31. Data filed *(Month, Day, Year)*: FEB 13 2001

32. Registrar's Signature: Jennie D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04011

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Antoine Eric Alexander

2. Date of Death (Month, Day, Year): February 6, 2001

3. Time of Death: 18:10 PM

4a. Facility Name *(If not institution, give street and number)*: Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 073-58-5390

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 32 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 28, 1968

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 1739 Homestead Street

10f. Zip Code: 21218

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 | College (1-4 or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Server

16b. Kind of Business/Industry: Hospitality

17. Father's Name *(First, Middle, Last)*: Luke Alexander

18. Mother's Name *(First, Middle, Maiden Surname)*: Edwanda Boozer

19a. Informant's Name/Relationship *(Type, Print)*: Edwanda Harris /Mother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1127 Homestead Street, Baltimore, MD 21218

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Chesapeake Crematory | Date: Feb 10 2001

20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: [signature] MN0986

22. Name and Address of Facility: Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ARDS	5 days
Due to (or as a consequence of):	b. Severe Pancreatitis	23 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. Pneumonia	10 days
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HIV disease, Anemia

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Chun Hong MD, Ph.D.

29c. License number: AT 2438946

29d. Date signed *(Month, Day, Year)*: February 6, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Chun Hong MD. Union Memorial Hospital 201 E Univ Pkwy Baltimore, MD 21218

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 13 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04012

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frederick Lee Adams

2. Data of Death — Month: February Day: 8 Year: 2001

3. Time of Death: 11:30 AM

4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 149-26-6110

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 67 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): 10-28-1933

9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 9900 Georgia Ave., Apt. 617

10f. Zip Code: 20910

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black African American

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Consultant

16b. Kind of Business/Industry: Marketing

17. Father's Name (First, Middle, Last): Foster Adams

18. Mother's Name (First, Middle, Maiden Surname): Ellen Chavis

19a. Informant's Name/Relationship (Type, Print): Robin Burriss

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 48 Scarlet Sage Crt., Burtonsville, MD., 20866

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore/Wash. Cremetory — Date: 02/14/01

20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: Deborah M Davis

22. Name and Address of Facility: Fleck Funeral Home, 7601 Sandy Spring Road, Laurel, MD., 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Aortic Aneurysm

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Steven Fuller

29c. Licensa number: H36078

29d. Date signed (Month, Day, Year): 2/9/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): STEVEN Fuller 7600 Carroll Ave., Takoma Park, MD 20912

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001

32. Registrar's Signature: Sandra G Sparks

ORIGINAL

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04013

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Chelsea H. Andrews
2. Data of Death (Month, Day, Yaar): February 10, 2001
3. Tima of Death: 4:40 pm
4a. Facility Nama (If not institution, giva street and number): 1206 Marion Quimby Drive
4b. City, Town, or Location of Daath: Stevensville
4c. County of Deeth: Queen Annes

Funeral Director

5. Social Security Number: 219-31-2513
6. Sax: 1☐ M 2☒ F
7. Aga (In yrs. last birthday): 9 Yrs.
If Undar 1 Yaar: Months / Days
If Undar 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Dey, Year): FEB. 25, 1991
9. Birthplace (Stata or Foraign Country): MARYLAND

Usual Residence of Decedant

10a. Stata: MARYLAND
10b. County: QUEEN ANNES
10c. City, Town or Location: STEVENSVILLE
10d. Insida City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 1206 MARION QUIMBY DRIVE
10f. Zip Code: 21666
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☒ Nevar Marriad 2☐ Marriad 3☐ Widowed 4☐ Divorced
12. Was Dacedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yes, Giva Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No Specify:
14. Race - Amarican Indian, Black, Whita, atc. Specify: WHITE

15. Decedent's Education (Specify only highast greda completed): Elementary/Secondary (0-12): 2; Collega (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired): STUDENT
16b. Kind of Business/Industry:

17. Fathar's Nama (First, Middle, Last): RANDALL W. ANDREWS
18. Mother's Nama (First, Middle, Maidan Surnama): SALLY K. BLEDSOE

19a. Informant's Name/Ralationship (Type, Print): SALLY K. ANDREWS (MOTHER)
19b. Mailing Addrass (Straet and Number or Rurel Routa Number, City or Town, Stata, Zip Coda): 1206 MARION QUIMBY DRIVE, STEVENSVILLE, MD. 21666

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Nama of cematery, crematory or othar place): GLEN HAVEN MEMORIAL PARK
Date: 2/16/2001
20c. Location - City or Town, State: GLEN BURNIE, MD.

21. Signature of Funaral Sarvice Licensee: [signature]
22. Nama and Addrass of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23e. Part 1. Entar the diseese, or complicetions that ceused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only ona causa *on* aach lina.

Approximata Intarval Batwaan Onset and Death

Immediata Causa (Finat disaese or condition resulting in daath)
a. Ependymoma — 29 months
Due to (or as a consequance of):
b.
Dua to (or as a consequence of):
Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Causa (Disaase or injury that initiated evants resulting in death) Last
c.
Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yas 2☐ No
24b. Wara autopsy findings availabla prior to compliation of ceusa of death? 1☐ Yas 2☒ No

25. Was casa rafarred to medical examinar? 1☐ Yas 2☒ No

26. Placa of Daath (Chack only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Othar: 4☐ Nursing Homa 5☒ Residance 6☐ Othar (Specify)

27. Mannar of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding Invastigation 6☐ Could not be datarmined
28a. Data of Injury (Month, Dey Year)
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Cartifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledge, deeth occurred at tha tima, data and place, and dua to the causa(s) and mannar es steted. 2☐ **Medical Examiner:** On tha basis of examination and/or invastigation, in my opinion, daath occurrad at tha tima, data and ptace, and due to tha causa(s) and mannar stated.

29b. Signatura and title of certifier: [signature] clinical MD Fellow
29c. Licansa number: D00053214
29d. Data signad (Month, Day, Year): February 12, 2001
30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Meghan A Higman, MD CMSC 800 Pediatric Oncology 600 North Wolfe Street Baltimore, Maryland 21287

State Registrar

31. Data filed (Month, Day, Year): FEB 13 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pegas 1 and 2 should be filed within 72 hours after daath with tha Maryland Department of Haalth and Mental Hygiana. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the daath certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by tha attanding physician and completely filled in by tha funaral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04014

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FREDA ACORD
2. Data of Death (Month, Day, Yaar): FEBRUARY 6 2001
3. Tima of Death: 0854
4a. Facility Nama (If not institution, giva street and number): NORTHWEST HOSPITAL
4b. City, Town, or Location of Daath: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 409-44-5210
6. Sax: 1☐ M 2☒F
7. Aga (In yrs. last birthday): 73 Yrs. — If Under 1 Yaar: Months / Days — If Undar 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Yaar): July 19,1927
9. Birthplaca (Stata or Foraign Country): Nebraska

Usual Residence of Decedant

10a. Stata: Maryland
10b. County: Baltimore
10c. City, Town or Location: Reisterstown
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Straet and Number: 48 Ewing Drive
10f. Zip Coda: 21136
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Navar Marriad 2☐ Marriad 3☐ Widowad 4☒ Divorcad
12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- if Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:
14. Race - Amaricen Indian, Black, Whita, atc. Spacify: White

15. Decedent's Education (Specify only highast grada complatad): Elamantary/Secondary (0-12): 12 — Collega (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): Dietician
16b. Kind of Businass/Industry: Nursing Home

17. Fathar's Nama (First, Middla, Last): Havery Cardwell
18. Mothar's Nama (First, Middla, Maidan Sumama): Rebecca V. Evans

19a. Informant's Name/Ralationship (Type, Print): Tammy Sunderland(Niece)
19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 7206 Crown Road Glen Burnie, MD 21060

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Placa of Disposition (Nama of cematary, cramatory or othar placa): Bayview Crematory — Data: 2/8/01
20c. Location - City or Town, Stata: Baltimore, MD

21. Signatura of Funaral Service Licensee: Shannon Liggett
22. Nama and Addrass of Facility: Gonce Funeral Home, P.A. 4001 Ritchie Hwy Baltimore, MD 21225

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina. — Approximata Intarval Batwaan Onsat and Death

Immediata Causa (Final disaasa or condition rasulting in daath):
a. END STAGE COPD
Dua to (or as a consaquanca of):
b.
Saquantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiatad avants rasulting in daath) Last
Dua to (or as a consaquanca of):
c.
Dua to (or as a consaquanca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying ceusa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Wara autopsy findings availabla prior to complation of ceusa of daath? 1☐ Yas 2☒ No

25. Was cesa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Placa of Daath (Check only ona)
Hospital: 1☒ Inpatiant 2☐ ER/Outpatiant 3☐ DOA
Other: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Yaar)
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurrad

28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)
28f. Location (Street and Numbar or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1☒ **Certifying Physician:** To tha best of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as statad. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar statad.

29b. Signatura and title of certifier: C. Ravi MD
29c. Licansa numbar: D37733
29d. Data signad (Month, Day, Yaar): FEBRUARY 6, 2001

30. Nama and addrass of parson who complatad causa of daath (Itam 23a) (Type, Print): C. RAVI MD, NHC, BALTO. MD 21133

State Registrar

31. Data filad (Month, Day, Yaar): FEB 13 2001
32. Registrar's Signatura: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

FRANK ADAMS AKA. FRANK ADAMS KT

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04015

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Frank J. Adams AKA: Frank J. Adamski
2. Date of Death Month Day Year: February 6 2001
3. Time of Death: 5:15 P.m.
4a. Facility Name *(If not institution, give street and number)*: North Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 219 03 1582
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 23, 1920
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Linthicum
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6318 Orchard Road
10f. Zip Code: 21090
10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: W.W.II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Quality Inspector
16b. Kind of Business/Industry: General Electric

17. Father's Name *(First, Middle, Last)*: Martin Adamski
18. Mother's Name *(First, Middle, Maiden Surname)*: Josephine Hoffman

19a. Informant's Name/Relationship *(Type, Print)*: David Adamski / Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7802 Ruanne Court Pasadena, Maryland 21122

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Glen Haven Memorial Park
Date: 2/10/01
20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: Jerome Francomano
22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one cause on eech line. — Approximate Intervel Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in death): e. SEPTICEMIA

Due to (or es e consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last:
b. GASTRO-INTESTINAL BLEEDING
Due to (or es a consequenca of):
c. CONGESTIVE HEART FAILURE
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Plece of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Mennor of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner steted.
29b. Signeture end title of certifier: MD
29c. License number: D43977
29d. Date signed *(Month, Day, Year)*: February 6 2001
30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): Ayoka Owusu-Ofori, 301 Hospital Drive, Glen Burnie MD 21061 (410-787-4999)

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 13 2001
32. Registrar's Signature: B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

15th

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04016

AMEND#30 (PER D.V.R.) G792 2-13-2001 JAB

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Corine Bullard	2/7/01	3:00 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Suburban Hospital	Bethesda	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
124-16-3190	1☐ M 2☒ F	81 Yrs.			10/8/19	Bahamas

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md	Montgomery	Sliver Spring	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
12106 Dewey Road	20906	Bahamas

11. Maritel Stetus	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Superison	Private

17. Fether's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumeme)
Nathaniel Rolle	Mamie Elizabeth Bain

19a. Informant's Name/Relationship (Type, Pnint)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
Annette Carter/ daughter	925 West Lake Drive, Mitchellville, Md 20721

20a. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
1☒ Buriel 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Dade Memorial Cemetery	2/14/01	Miami, Fla.

21. Signature of Funeral Service Licensee		22. Name end Address of Facility
[signature]	CC0348	Latney's Funeral Home, Inc. 3831 Georgia Avenue,NW Wash.,DC 20011

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)
a. Coronary Artery disease.

Due to (or as a consequence of):
b. Myocardial Infarction.

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Chronic lymphocytic Leukemia

Due to (or as a consequence of):
d. Renal Failure

Part II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uae contribute to the cauae of death? 1☐ Yee 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of ceuse of deeth?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end menner as stated.
2☐ **Medical Examiner:** On the besis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
[signature]	D52767	02/08/2001

30. Name and eddress of person who completed ceuse of death (Item 23a) (Type, Print)
HARMINDER SINGH SETHI SUBURBAN HOSPITAL BETHESDA MARYLAND

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrer's Signature
FEB 13 2001	[signature] G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Corine Bullard 2/7/2001 3:00 PM

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 04017

Physician /Medical Examiner

1. Decedant's Name (First, Middle, Last)	2. Date of Death Month Day Yaar	3. Time of Daath
Esther Brown	February 11, 2001	6:25 pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
North Arundel Hospital	Glen Burnie	AA County

Funeral Director

5. Social Security Number	6. Sex	7. Aga (In yrs. last birthday)	If Undar 1 Year: Months / Days	If Undar 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Yaar)	9. Birthplace (State or Foreign Country)
219-38-0825	1☐ M 2☑ F	60 Yrs.			01-31-1941	MD.

Usual Rasidance of Decedent

10a. Stata	10b. County	10c. City, Town or Location	10d. Insida City Limits
MD	N/A	Baltimore	1☑ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4108 Edmonson Ave	21229	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Dacedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, Whita, atc.
1☐ Nevar Married 2☑ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☑ No If Yes, Giva Year or Dates:	1☐ Yes 2☑ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade complatad)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elamantary/Sacondary (0-12)	College (1-4or 5+)		
12th Grade		Domestic	House wife

17. Father's Name (First, Middla, Last)	18. Mothar's Nama (First, Middla, Maiden Sumame)
Silas McCargo	Esther Palmer

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda)
George R. Brown Sr. (Husband)	4108 Edmonson Ave Balto. MD. 21229

20a. Method of Disposition	20b. Placa of Disposition (Nama of camatery, crematory or other placa)	Date	20c. Location - City or Town, State
1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)		2/16/01	

21. Signatura of Funeral Service Licensee	22. Nama and Address of Facility
Vaughn C Greene	Vaughn C. Greene Funeral Services 5151 Balto. Nat'l Pike Balto MD. 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Causa (Final diseasa or condition resulting in daath)

a. PROB MASSIVE MYOCARDIAL INFARCTION

Dua to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. PROB MALIGNANT ARRHYTHMIA

Due to (or as a consequanca of):

c. CONGESTIVE CARDIOMYOPATHY

Due to (or as a consequence of):

d. HYPERTENSION

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Data of dalivary Month Day Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at tima of daath 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yas 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed?	24b. Wara autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☑ No

25. Was casa referred to madical examiner?	26. Placa of Death (Check only one)	
1☑ Yes 2☐ No	Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA	Othar: 4☐ Nursing Home 5☐ Residanca 6☐ Other (Specify)

27. Manner of Death	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be determined		M	1☐ Yas 2☐ No	

28e. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowladge, death occurrad at tha time, date and place, and dua to tha cause(s) and mannar as stated. 2☐ **Medical Examinar:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D0033215	2/12/01

30. Name and address of person who completed cause of death (Item 29a) (Type, Print)

Shirley Thompson-Richards M.D. 7401 Osler Drive Ste M1 Towson, MD 21204

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 13 2001	Sandra G. Sparks

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04018

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Vivian Estella Brown
2. Date of Death (Month, Day, Year): Feb. 7, 2001
3. Time of Death: 1:00 A.M.
4a. Facility Name (If not institution, give street and number): Genesis ElderCare- Cromwell Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-24-6487
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 16, 1930
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☐ No
10e. Street and Number: 830 Lenton Avenue
10f. Zip Code: 21212
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4 Years
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Social Worker
16b. Kind of Business/Industry: Baltimore City

17. Father's Name (First, Middle, Last): Joseph J. James, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Vivian Thornton

19a. Informant's Name/Relationship (Type, Print): Barbara Hill/ Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5102 Kenilworth Avenue Baltimore, Maryland 21212

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Pleasant Rest Cemetery | Date: 2/10/200
20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Geo. Harris
22. Name and Address of Facility: Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, Maryland 21215

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. stroke — 1 months

Due to (or as a consequence of):
b. metastatic cancer, unknown primary — unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
pulmonary embolism

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Carl S. Friedman, MD
29c. License number: D20688
29d. Date signed (Month, Day, Year): 2/8/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Carl S. Friedman, MD, 515 Fairmount Ave, Towson, Md. 21286

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

98-6

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04019

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elma Briggs
2. Date of Death (Month, Dey, Year): 02 08 2001
3. Time of Death: 8:30p.m.
4a. Facility Name (If not institution, give street and number): Mariner Health Care
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 246-12-6520
6. Sex: 1☐ M 2☒ F XX
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 09 23 23
9. Birthplace (State or Foreign Country): S.C.

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4025 Frederick Ave
10f. Zip Code: 21229
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Americen Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade | College (1-4or 5+): na
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Private Home

17. Father's Name (First, Middle, Last): Murray Fludde
18. Mother's Name (First, Middle, Maiden Surname): Esther King

19a. Informant's Name/Relationship (Type, Print): Ernest Briggs Jr.-Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 314 Belltown Road, Owings Mills, Md 21117

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Arbutus Cemetery
Date: 2/13/01
20c. Location - City or Town, State: Arbutus, Md

21. Signature of Funeral Service Licensee: Jerome A. Thompson
22. Name and Address of Facility: March F/H West 21215 4300 Wabash Ave, Baltimore, Maryland

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Chronic obstructive Lung disease	10yrs.
Due to (or es e consequence of): b.	congestive heart failure	2yrs.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): c.	obstructive Sleep apnea	2yrs.
d.		

Part II. Other significant conditiona contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: physician
29c. License number: D29769
29d. Date signed (Month, Day, Year): 2/9/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): marcelino D. Alboverne MD 516 N. Rolling Rd Balto md 21228

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Albert	Lee	Bagby	02	09	2001	7:35p.m.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Catonsville Nursing Home	Catonsville	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
229-22-0775	XX 1☐M 2☐F	75 Yrs.					10 30 25	V.A.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	XX 1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2926 Riggs Ave	21216	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married XX Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No X Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
4th grade	na	Mechanic	Balto Gas & Elec.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Oscar Bagby	Cora Holmes

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Raymond L. Johnson-Son	2926 Riggs Ave, Baltimore Md 21216

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	King Memorial Park	2/14/01	Randallstown, Md

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Elaine A. Thompson	March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic Prostate Cancer	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

End Stage Dementia
Diabetes Mellitus
Decubitus Ulcers

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☐Unknown	1☐Yes 2☐No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Shalini Tewari MD	D52671	February 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Shalini Tewari 1838 Greene Tree Rd Suite 300 Pikesville, MD 21208

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 13 2001	D. Sparks

State Registrar

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04021

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: June D. Betz

2. Data of Death Month Day Year: February 11, 2001

3. Time of Death: 7:58 AM

4a. Facility Name *(If not institution, give street and number)*: Crofton Convalescent Home

4b. City, Town, or Location of Death: Crofton

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 219-28-7898

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 67 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: MAY 29, 1933

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residance of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Insida City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 200 Wicklow Avenue

10f. Zip Coda: 21061

10g. Citizan of What Country?: USA

11. Marital Status: 1☒ Nevar Marriad 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☒ Yas 2☐ No If Yes, Giva Year or Datas: 1950-1952

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Amaricen Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada complatad)*: Elamantary/Secondary (0-12): Collega (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratirad)*: Nurse

16b. Kind of Businass/Industry: Hospital

17. Father's Nama *(First, Middla, Last)*: Roland Betz

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Victoria H. Miller

19a. Informant's Name/Ralationship *(Type, Print)*: Regina D. Price/Cousin

19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 4 Sunset Circle Pasadena, MD 21122

20a. Mathod of Disposition: 1☐ Burial 2☒ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of camatary, cramatory or othar placa)*: Metro Crematory Inc.

Data: 2-12-01

20c. Location - City or Town, Stata: Baltimore, MD

21. Signature of Funeral Sarvice Licensee: Thomas Gregor

22. Nama and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Entar tha diseasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List *only* ona *causa on* aach lina.

Approximata Intarval Batween Onsat and Daath

Immediata Causa (Finat disaasa or condition rasulting in daath)

a. Multiple Myeloma — 2yrs.

Dua to (or as a consequance of):

Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaasa or injury that initiated evants rasulting in daath) Last

b.

Dua to (or as a consequance of):

c.

Dua to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Wara autopsy findings availabla prior to complation of causa of daath? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☑ No

26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA Othar: 4☑ Nursing Homa 5☐ Rasidanca 6☐ Othar *(Specify)*

27. Mannar of Death: 1☐ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurrad

28a. Place of Injury - At homa, farm, street, factory, offica building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☑ **Certifying Physician**: To tha best of my knowladga, death occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner**: On the basis of examination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar stated.

29b. Signatura and title of certifier: SMattu

29c. Licansa number: D52139

29d. Data signad *(Month, Day, Year)*: February 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SEJAL MATTU 4175 N. Hanson Ct. Suite 203A, Bowie, MD 20716

State Registrar

31. Data filed *(Month, Day, Year)*: FEB 13 2001

32. Registrar's Signatura: Geneva D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pagas 1 and 2 should be filed within 72 hours after daath with tha Maryland Departmant of Haalth and Mental Hygiana. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic avent, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law requires that the daath certificata be axecutad within 24 hours after death.
To the Funeral Director: After this certificata has been signed by the attanding physician and completely filled in by tha funaral director, paga 2 should be datached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04022

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John Nathan Billingslea

2. Date of Death (Month, Day, Year): February 10, 2001

3. Time of Death: 7:35AM

4a. Facility Name *(If not institution, give street and number)*: Gilchrist Center for Hospice Care

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-22-4048

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 12, 1926

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Pikesville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 7116 Walnut Ave.

10f. Zip Code: 21208

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1951-56

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2

16a. Kind of Work Done During Most of Working Life. *DO NOT use retired)*: Supervisor

16b. Kind of Business/Industry: Baltimore City Schools Transportation

17. Father's Name *(First, Middle, Last)*: James Nathan Billingslea

18. Mother's Name *(First, Middle, Maiden Surname)*: Louella Jones

19a. Informant's Name/Relationship *(Type, Print)*: Ruthelma C. Billingslea Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7116 Walnut Ave., Pikesville, MD 21208

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MD National Memorial Park

Date: 2/14/01

20c. Location - City or Town, State: Laurel, MD

21. Signature of Funeral Service Licensee: John A. Shaw

22. Name and Address of Facility: Eline Funeral Home, 11824 Reisterstown Road, Reisterstown, MD 21136

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer — 3 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* Hospice

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Date of Injury *(Month, Day, Year)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: W. Anthony Riley, MD

29c. License number: D25205

29d. Date signed *(Month, Day, Year)*: February 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Balto. MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 13 2001

32. Registrar's Signature: Jennie G. Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

02-10-01 7:35 Am

Mr. John Billingslea

10+1

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04023

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ORVA LOUISE BYRON

2. Date of Death — Month: FEBRUARY; Day: 09; Year: 2001

3. Time of Death: 4:53 P.M.

4a. Facility Name *(If not institution, give street and number)*: HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 212-26-4774

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 70 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 4, 1930

9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 309 Patsy Avenue

10f. Zip Code: 21060

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Assembly Worker

16b. Kind of Business/Industry: Window Treatment

17. Father's Name *(First, Middle, Last)*: Ottie Harris

18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth Simmons

19a. Informant's Name/Relationship *(Type, Print)*: Albert W. Byron (Husband)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 309 Patsy Avenue Glen Burnie, Maryland 21060

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Cremation Center, LLC

Date: Feb. 11, 2001

20c. Location - City or Town, State: Stevensville, Maryland

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: Singleton Funeral Home, P.A.
1 Second Avenue, S.W.
Glen Burnie, Maryland 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. SEPTIC SHOCK — 1 day

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. MESENTRIC ISCHEMIC GANGRENE — 1day

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

1) HYPERTENSION 2) DIABETES MELLITUS
3) PERIPHERAL VASCULAR DISEASE 4) LUNG CARCINOMA.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.

29c. License number: P13472

29d. Date signed *(Month, Day, Year)*: Feb, 09, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SANDEEP GAUTAM, HARBOR HOSPITAL, MD 21061

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 13 2001

32. Registrar's Signature: Deputy G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 04024

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BENEDICT A BLUM
2. Date of Death — Month: FEBRUARY Day: 12 Year: 2001
3. Time of Death: 4:55 AM.
4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216 05 1170
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 93 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 7, 1907
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 301 Jeffrey Street
10f. Zip Code: 21225
10g. Citizen of What Country?: U.S.
11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: W.W. II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Superintendent Clothing Division
16b. Kind of Business/Industry: State of Maryland
17. Father's Name (First, Middle, Last): Charles Blum
18. Mother's Name (First, Middle, Maiden Surname): Anna Grandy
19a. Informant's Name/Relationship (Type, Print): Benedict A. Blum / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1104 Harlon Way BelAir, Maryland 21014
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Holy Cross Cemetery
Date: 2/15/01
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: Donna M Zramiowski
22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory failure — 1 day
Due to (or as a consequence of):
b. Metastatic Sarcoma — 2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one) — Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] M.D
29c. License number: AS2441614A42
29d. Date signed (Month, Day, Year): February, 12, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 3001 S. Hanover Street Baltimore MD 21225

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04025

Coleman, Catherine

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CATHERINE A. COLEMAN

2. Data of Death (Month, Day, Yaar): February 10 2001

3. Tima of Death: 12:40 A.M

4a. Facility Name (If not institution, giva street and number): North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 422-28-8313

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC 18 1926

9. Birthplaca (State or Foraign Country): ALABAMA

Usual Residance of Decedent

10a. State: MARYLAND

10b. County: HARFORD CO

10c. City, Town or Location: ABERDEEN

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1416 PERRYWOOD DRIVE

10f. Zip Code: 21001

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Ricen, etc.) 1☐ Yas 2☒ No Specify:

14. Race - American Indian, Black, Whita, etc. Specify: BLACK

15. Decedent's Educetion (Specify only highast grade completed)

Elemantary/Secondery (0-12): 12yrs

Collega (1-4or 5+): 3yrs

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): NURSES AIDE

16b. Kind of Business/Industry: HEALTH

17. Fathar's Nama (First, Middle, Last): unknown

18. Mothar's Nama (First, Middle, Maiden Sumama): EMMA A EDWARDS

19a. Informant's Name/Relationship (Type, Print): Frances Coleman Joyner/Daughter

19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, State, Zip Coda): 1416 Perrywood Dr., Aberdeen, Md, 21001

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from State 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Nama of cematary, cramatory or othar place): BALTIMORE NATIONAL

Data: 2-16-01

20c. Location - City or Town, Stata: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Charles D. Small

22. Name and Address of Facility: WILLIAM C BROWN COMMUNITY FUNERAL HOME PA
321 S PHILADELPHIA BLVD, ABERDEEN, MD, 21001

Physician /Medical Examiner

23a. Part I. Enter the disaasa, or complications that ceusad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart feilura. List only one causa on each lina.

Approximata Intarval Batween Onset and Death

Immediata Ceusa (Final disease or condition resulting in death): a. ASPIRATION PNEUMONIA

Dua to (or as a consequance of): b. STROKE SIS

Sequentially list conditions, if any, leading to immediata cause. Entar Undarlying Cause (Diseasa or injury that initiated events resulting in death) Last: Dua to (or as a consequance of): c. CHRONIC RENAL FAILURE

Dua to (or as a consequance of): d.

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying ceusa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Wara autopsy findings available prior to completion of ceuse of daath? 1☐ Yas 2☐ No

25. Was cese referred to medical examinar? 1☐ Yas 2☑ No

26. Placa of Death (Check only ona): Hospital: 1☑ Inpatiant 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Plece of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledga, death occurred at the tima, date and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurred at the time, dete end place, and dua to the cause(s) and manner stated.

29b. Signatura and title of certifier: MM

29c. Licanse number: D 43477

29d. Date signed (Month, Day, Year): February 10 2001

30. Nama and addrass of person who complated causa of daath (Item 23a) (Type, Print): Ayden Okerinyi 301 Hospital Drive, Glen Burnie MD 21061

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001

32. Registrar's Signatura: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04026

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Boyd Nathaniel Cook
2. Date of Death (Month, Day, Year): Feb. 9, 2001
3. Time of Death: 10:20PM
4a. Facility Name (If not institution, give street and number): Riverview Nursing Solutions
4b. City, Town, or Location of Death: Essex
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 230-14-4708
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 75 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 18, 1925
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 X Yes 2 ☐ No
10e. Street and Number: 124 West Franklin Street #409
10f. Zip Code: 21201
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Nevar Married 2 ☐ Married 3 ☐ Widowed 4 X Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 X No Specify:
14. Raca - Amarican Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired): Dry Cleaner / Clothier
16b. Kind of Business/Industry: Dry Cleaning

17. Father's Name (First, Middla, Last): John Henderson Cook
18. Mother's Name (First, Middle, Maiden Surnama): Ethel May Davis

19a. Intormant's Name/Relationship (Type, Pnnt): Mary W. Jones / daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 124 West Franklin Street #409 Baltimore, MD 21201

20e. Method of Disposition: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory, Inc. — Date: 2/12/01
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Nama and Addrass of Facility: CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures DR., Towson, MD 21286

Physician /Medical Examiner

23a. Part I. Enter tha diseasa, or complications that caused the death. Do not enter the mode ot dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Intervel Between Onset and Death

Immediate Ceuse (Finel disaase or condition resulting in death): a. Metastatic Prostate Cancer — 3-4 yrs

Due to (or as a consequenca of):

Sequentially list conditions, if any, laeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated avents resulting in death) Last:
b.
Due to (or as a consequenca of):
c.
Due to (or as a consequenca of):
d.

Part tt. **Other significant conditions** contributing to death but not resulting tn the underlying cause given in Part I.: Type II DM, HTN, CHF. COPD

23b. Did tobacco uee contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No
24b. Were eutopsy findings available prior to complation of cause ot deeth? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No

26. Place of Deeth (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify)

27. Menner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Placa ot Injury - At home, tarm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the ceuse(s) and manner steted.

29b. Signature and titte of certifiar: ▶ [signature] MD
29c. License number: D-38754
29d. Date signed (Month, Day, Year): 02-11-2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): MALIKA WASEEM, 709 EASTERN BLVD, MD-21221

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001
32. Registrar's Signature: ▶ [signature] D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04027

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Billie I. Clark
2. Date of Death: Month Feb, Day 8, Year 01
3. Time of Death: 06:00a
4a. Facility Name (If not institution, give street and number): Montclaire Manor Assisted Living
4b. City, Town, or Location of Death: Fulton
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 105-05-6488
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. — If Under 1 Year: Months, Days; If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): May 26, 1911
9. Birthplace (State or Foreign Country): England

Usual Residence of Decedent

10a. State: MD
10b. County: Howard
10c. City, Town or Location: Fulton
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11805 Wayne Ridge Road
10f. Zip Code: 20759
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales
16b. Kind of Business/Industry: Retail

17. Father's Name (First, Middle, Last): Hyman Abrams
18. Mother's Name (First, Middle, Maiden Surname): Fanny Silverman

19a. Informant's Name/Relationship (Type, Print): Michael J. Clark-son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9349 Indian Camp Road, Columbia, MD., 21045

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): FountainHead Memorial Park — Date: 02/12/2001
20c. Location - City or Town, State: Palm Bay, Florida

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: FountainHead Memorial Park, Palm Bay, Florida

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. gastrointestinal Bleeding — months
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: 0-53636
29d. Date signed (Month, Day, Year): Feb 8, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): KEVIN CARLSON 3460 Ellicott Center Drive Ellicott City MD 21043

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001
32. Registrar's Signature: [signature]

ORIGINAL

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 04028

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ima Cecelia Cavey
2. Date of Death (Month, Day, Year): Feb. 11, 2001
3. Time of Death: 11:30 AM

4a. Facility Name (If not institution, give street and number): Noble House 2327 N. Charles Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-07-4644
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 26, 1911
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 606 Harding Place
10f. Zip Code: 21211
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: In Own Home

17. Father's Name (First, Middle, Last): William Kelbaugh
18. Mother's Name (First, Middle, Maiden Surname): Laura Susan Ament

19a. Informant's Name/Relationship (Type, Print): Denise Wheeler Grandchild
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 606 Harding Place Baltimore, Maryland 21211

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem. | Date: 2/14/01
20c. Location - City or Town, State: Cockeysville, Maryland

21. Signature of Funeral Service Licensee: Nancy H. Carpenter
22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Congestive Heart Failure — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Pelvic Cystic Mass

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.
29b. Signature and title of certifier: Robert Oneal
29c. License number: D23076
29d. Date signed (Month, Day, Year): 2-12-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 3730 FALLS RD BALTIMORE MD 21211

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001
32. Registrar's Signature: B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04029

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Donald Henry Carstens
2. Date of Death Month / Day / Year: February 11, 2001
3. Time of Death: 8:00 AM
4e. Facility Name *(If not Institution, give street and number)*: 919 Topmast Way
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 215-16-0978
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 79 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: FEB 8, 1922
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 919 Topmast Way
10f. Zip Code: 21401
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Contractor
16b. Kind of Business/Industry: Self-Employed

17. Father's Name *(First, Middle, Last)*: John Henry Carstens
18. Mother's Name *(First, Middle, Maiden Surname)*: Marie Luers

19a. Informant's Name/Relationship *(Type, Print)*: Mary H. Carstens/Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 919 Topmast Way Annapolis, MD 21401

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory Inc. — Date: 2-12-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas Gregor
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): e. Renal cell carcinoma — Approximate Interval Between Onset and Death: 4 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: S. Selonich, M.D.
29c. License number: D19838
29d. Date signed *(Month, Day, Year)*: 2/12/2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Stuart E. Selonich, M.D. 900 Bestgate Rd. Annapolis, Md.

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 13 2001
32. Registrar's Signature: Jennie D. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04030

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROSE V. CROTSLEY
2. Date of Death (Month, Day, Year): FEBRUARY 12, 2001
3. Time of Death: 6:25AM
4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN NURSING CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-26-5704
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 09-24-1916
9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: XX Yes 2☐ No
10e. Street and Number: 1601 EAST BELVEDERE AVENUE
10f. Zip Code: 21239
10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1☐ Never Married 2☐ Married XX Widowed 4☐ Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes XX No If Yes, Give Year or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes XX No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 YEARS; College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): NURSING ASSISTANT
16b. Kind of Business/Industry: HEALTH CARE

17. Fether's Neme (First, Middle, Last): HENRY V. PETTIS
18. Mother's Name (First, Middle, Maiden Surname): IDA DANCE

19a. Informent's Neme/Reletionship (Type, Print): RUTH V.DiBLASI (DAUGHTER)
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 509 H.CIDAR PRESS CT.,JOPPA,MD.,21085

20a. Method of Disposition: XX Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Placa of Disposition (Name of cemetery, cremetory or other place): PARKWOOD CEMETERY
Date: 2-14
20c. Location - City or Town, State: BALTO.,MD.,21234

21. Signeture of Funeral Service Licensee: R. J. Ruth
22. Name and Address of Facility: HENRY W. JENKINS AND SONS COMPANY 6500 YORK ROAD,BALTIMORE,MARYLAND,21212

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediete Ceuse (Final disease or condition resulting in deeth)
e. Pneumonia — Dayo

Due to (or as a consequence of):
b. Dementia — years

Sequentielly list conditions, if any, leading to immediete cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☑ No
24b. Were eutopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Mennor of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Day Yeer):
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred:
28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify):
28f. Location (Street and Number or Rural Route Number, City or Town, Stete):

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) end manner es stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier: C. Vergara-Soares, M.D.
29c. License number: D16619
29d. Date signed (Month, Day, Year): 2/12/01

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): C. VERGARA-SOARES 1601 E. BELVEDERE AVE. BALTIMORE, MD. 21239

State Registrar

31. Dete filed (Month, Dey, Yeer): FEB 13 2001
32. Registrer's Signeture: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04031

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William John Downey
2. Date of Death (Month, Day, Year): February 12, 2001
3. Time of Death: 10:00 am
4a. Facility Name (If not institution, give street and number): Heritage Nursing Center
4b. City, Town, or Location of Death: Dundalk
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212 20 4344
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 73 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 2, 1927
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedant

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1408 Galena Rd.
10f. Zip Code: 21221
10g. Citizen of Whet Country?: USA

11. Maritel Stetus: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Giva Yeer or Detes: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Raca - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 7; College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa retired): Printer
16b. Kind of Business/Industry: Railroad

17. Fether's Neme (First, Middle, Last): John Edward Downey
18. Mother's Name (First, Middle, Maiden Surneme): Charlotte Wright

19a. Informant's Neme/Relationship (Type, Print): Gladys Benges (Sister)
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 1143 Carroll St. Baltimore, Md. 21230

20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other piece): Green Mount Crematory
Dete: 2/14/2001
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: ▶ John W. Burkowske MO1091
22. Name end Address of Facility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221

Physician /Medical Examiner

23a. Part I. Entar tha diseese, or complications that caused the deeth. Do not enter tha mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximate Intervel Betwean Onset end Deeth

Immediata Cause (Finel diseese or condition resulting in daath)
e. CORONARY ARTERY DISEASE
Due to (or es a consequance of):
b. CEREBROVASCULAR ACCIDENT
Due to (or es e consequenca of):
c. HEART BLOCK
Due to (or es e consequence of):
d. PACEMAKER INSERTION

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes en autopsy performad? 1☐ Yes 2☑ No
24b. Were eutopsy findings eveilabla prior to completion of cause of daath? 1☐ Yas 2☑ No

25. Wes case raferred to medical examiner? 1☐ Yes 2☑ No
26. Place of Deeth (Check only one): Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Homa 5☐ Residenca 6☐ Other (Specify)

27. Menner of Death: 1☐ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigetion 6☐ Could not be determined
28a. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)
28b. Time of Injury: M
28c. Injury et Work? 1☐ Yas 2☐ No
28d. Dascribe how injury ocurrad
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifiar (Check only one): 1☑ **Certifying Phyeician:** To the best of my knowledge, deeth occurred et tha tima, data end place, and dua to tha causa(s) and mannar as steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurrad et tha tima, date end piece, and dua to the ceuse(s) and menner steted.

29b. Signature and title of certifier: ▶ Satinder K Sodhi MD
29c. License number: D27188
29d. Date signed (Month, Day, Year): 2/12/01

30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print): Satinder K Sodhi 2 Market Place Baltimore MD 21202

State Registrar

31. Deta filed (Month, Dey, Yeer): FEB 13 2001
32. Registrer's Signeture: ▶

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha daath certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 04032

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Beryl Lucille Ford Davis	February 6, 2001	9:22 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Roland Park Place Health Care Ctr.	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-30-4999	1☐M 2☒F	91 Yrs.			June 9, 1909	Jacksonville, TX

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	N/A	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
Roland Park Place 830 W. 40th Street	21211	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5	School Teacher	Education Prince George County, MD

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Fred Hugo Ford	Beryl Star Reiney

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
B. Ford Davis Son	4805 Keswick Road Baltimore, Maryland 21210

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Warrenton Cemetery	2/9/2001	Warrenton, Virginia

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Gregory K. Carpenter	Burgee-Henss-Seitz Funeral Home, Inc, 3631 Falls Road Baltimore, Maryland 21211

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	CVA	2 Weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of): ASCVD	10 yrs
	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Gregory K. Walker MD	D25612	2/7/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Gregory Walker 201 E. University Parkway Baltimore, Maryland 21218

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 13 2001	▶ Teresa D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04033

AMEND#10g PER F.H. G792 2-13-2001 JAB

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MOJZESZ DZIUBKIEWICZ
2. Date of Death: Month FEBRUARY Day 09 Year 2001
3. Time of Death: 10:43 PM
4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 218-44-3851
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG.15,1914
9. Birthplace (State or Foreign Country): POLAND

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 7006 PARK HEIGHTS AVENUE #J-3
10f. Zip Code: 21215
10g. Citizen of What Country? ~~U.S.A.~~ CUBA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DEPARTMENT MANAGER
16b. Kind of Business/Industry: CLOTHING MANUFACTURING

17. Father's Name (First, Middle, Last): (UNKNOWN) DZIUBKIEWICZ
18. Mother's Name (First, Middle, Maiden Surname): FELICIA KAISER

19a. Informant's Name/Relationship (Type, Print): FELICIA DZIUBKIEWICZ / DAU.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7006 PARK HEIGHTS AVENUE #J-3, BALTIMORE, MD 21215

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): KOVNA CEMETERY
Date: 2/12/01
20c. Location - City or Town, State: ROSEDALE, MD

21. Signature of Funeral Service Licensee: Robert Levinson
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory erresf, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediefe Cause (Final disease or condition resulting in death): e. RENAL FAILURE

Due to (or as a consequenca of): SEPSIS

Sequenfially lisf conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequenca of):
c. Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HEART FAILURE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24e. Wes an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending invesfigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, streef, facfory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stefe)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) end menner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated.

29b. Signature end fitle of certifier: Todor, MD
29c. License number: D54352
29d. Date signed (Month, Day, Year): FEBRUARY, 12, 2001

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): MIRCEA TODOR
NORTHWEST HOSPITAL, 5401 OLD COURT ROAD, RANDALLSTOWN, MD 21133

State Registrar

31. Dafe filed (Month, Day, Year): FEB 13 2001
32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar Amend#10a,perfh #25 perPHYG792 2/13/2001 EW

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2001 04034

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): KENYA E. EZI
2. Date of Death: Month 2 Day 2 Year 2001
3. Time of Death: 7:16 PM
4a. Facility Name (If not institution, give street and number): University of Maryland Medical Center
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 213-94-7059
6. Sex: 1 M 2 F
7. Age (In yrs. last birthday): 22 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC. 28, 1978
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1 Yes 2 No
10e. Street and Number: 1951 W. FAYETTE STREET
10f. Zip Code: 21223
10g. Citizen of What Country? USA.

11. Marital Status: 1 Never Married 2 Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FOOD SERVICE
16b. Kind of Business/Industry: HOTEL INDUSTRY

17. Father's Name (First, Middle, Last): NWUJ EZI
18. Mother's Name (First, Middle, Meiden Surname): CORETTA BARKSDALE

19a. Informant's Name/Relationship (Type, Print): JENELYN WILSON (AUNT)
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1951 W. FAYETTE STREET, BALTO. MD. 21223

20a. Method of Disposition: 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS CEMETERY | Date: 02-08-01
20c. Location - City or Town, State: ARBUTUS, MARYLAND

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE, BALTIMORE, MD. 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. liver failure
Due to (or as e consequence of): b. Sepsis
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown
23c. If yes, outcome of pregnency: 1 Live birth 2 Fetel death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
24a. Was en autopsy performed? 1 Yes 2 No
24b. Were eutopsy findings available prior to completion of cause of deeth? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No
28. Place of Death (Check only one): Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 Residence 6 Other (Specify)
27. Menner of Deeth: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner es steted. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: P13397
29d. Date signed (Month, Dey, Yeer): 2/2/2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BABAK MOEINOLMOLKI 22 southgreen st BALTIMORE MD 21201

State Registrar

31. Date filed (Month, Dey, Yeer): FEB 13 2001
32. Registrar's Signature: Jennie D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04035

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Fannie Mae Evans

2. Date of Death: Month FEBRUARY Day 7 Year 2001

3. Time of Death: 10:55 A.M.

4a. Facility Name (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL CENTER

4b. City, Town, or Location of Death: ROSEDALE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 222-16-1586

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months Days

If Under 24 Hrs.: Hours Min.

8. Date of Birth (Month, Day, Year): 02-02-26

9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☐ No XX

10e. Street and Number: 1209 S. Marlyn Avenue

10f. Zip Code: 21221

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9th grade

College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic

16b. Kind of Business/Industry: in home

17. Father's Name (First, Middle, Last): Marcus Early

18. Mother's Name (First, Middle, Maiden Surname): Flora Dudley

19a. Informant's Name/Relationship (Type, Print): Marian Reed

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1209 S. Marlyn Avenue Baltimore, Md. 21221

20a. Method of Disposition: ☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Cem.

Date: 2/10/01

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: ▶ Gladys Ware

22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. SEPTIC SHOCK — 24 HOURS

Due to (or as a consequence of):

b. PNEUMONIA — 24 HOURS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ABDOMINAL AORTIC ANEURYSM REPAIR

AORTO ENTERIC FISTULA REPAIR

AXILLARY BIFEMORAL GRAFT SURGERY

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Lavanya Yarlagadda

29c. License number: D 203406

29d. Date signed (Month, Day, Year): FEBRUARY 7, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LAVANYA YARLAGADDA, MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001

32. Registrar's Signature: ▶ Geneva G. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

EVANS, FANNIE

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04036

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Patricia Ann Filer

2. Date of Death: Month February Day 10 Year 2001

3. Time of Death: 11:00 am

4a. Facility Name (If not institution, give street and number): 2802 Roselawn Avenue

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 217 40 3360

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 59 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): August 31, 1941

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2802 Roselawn Avenue

10f. Zip Code: 21214

10g. Citizen of Whet Country?: USA

11. Maritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 10 | College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Own Home

17. Father's Neme (First, Middle, Last): Robert B. Brown Sr.

18. Mother's Neme (First, Middle, Maiden Surname): Rita H. Keller

19a. Informent's Neme/Relationship (Type, Print): Robert Filer (Son)

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 2802 Roselawn Avenue Baltimore, Md. 21214

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other piece): Green Mount Crematory Date: 2/13/2001

20c. Location - City or Town, Stete: Baltimore, Md.

21. Signature of Funeral Service Licensee: John W. Burkowske MO1091

22. Name end Address of Feciliety: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Deeth

Immediete Ceuse (Final diseese or condition resulting in death)

e. Metastatic breast cancer — 3 yrs 6 mth

Due to (or es a consequenca of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest

b.

Due to (or as e consequenca of):

c.

Due to (or es a consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospitel: 1☐ inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) end menner steted.

29b. Signature and title of certifier: MD

29c. License number: D18487

29d. Date signed (Month, Day, Year): 2/12/01

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print): MYO THANT 8114 SANDPIPER CIRCLE, MD 21236

State Registrar

31. Dete filed (Month, Day, Year): FEB 13 2001

32. Registrar's Signeture: Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04037

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Celia Firestein
2. Deta of Death — Month: 2 Dey: 10 Yaar: 2001
3. Time of Deeth: 740 PM
4e Facility Neme (If not institution, give street and number): Levindale Hosp
4b. City, Town, or Location of Deeth: Balt MD
4c. County of Deeth: Balt City

Funeral Director

5. Social Security Number: 218-26-9638
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthdey): 92 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): 9-4-1908
9. Birthplace (Stete or Foreign Country): UKRAINE

Usual Residence of Decedent

10a. Stete: MD
10b. County: Balt
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 7920 SCOTTS LEVEL ROAD
10f. Zip Code: 21208
10g. Citizen of Whet Country?: U.S.A.
11. Meritel Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yas, Give Year or Datas:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specity Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No — Specify:
14. Race - Amerlcan Indian, Black, White, etc. — Specify: WHITE
15. Decedent's Education (Specify only highest grada completed) — Elementery/Secondery (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): TAILOR
16b. Kind of Business/Industry: GARMENT
17. Father's Neme (First, Middle, Last): RAPHAEL FIRESTEIN
18. Mother's Neme (First, Middle, Maiden Surneme): BESSIE ROTTENBERG
19e. Informant's Neme/Reletionship (Type, Print): EUGENE SIEGEL / NEPHEW
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1318 MIDWOOD PLACE - SILVER SPRING, MD 20910
20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): BETH JACOB ANSHE VESHEAR — Date: 2/11/01
20c. Location - City or Town, State: ROSEDALE, MD
21. Signature of Funeral Service Licensee: [signature]
22. Nama end Address of Fecility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or raspiretory errest, shock, or heert failure. List only one cause on eech line. — Approximata Intervel Between Onset end Death

Immediate Cause (Final diseese or condition resulting in deeth)
a. SEPSIS
Due to (or es e consequence of):
b. OSTEOMYELITIS OF LEFT FOOT

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last
Due to (or es a consequenca of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: ALZHEIMERS DEMENTIA

23b. Did tobacco uae contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy tindings available prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the beels of exeminetion end/or Invastigation, in my opinion, death occurred et the time, date end piece, end due to the ceuse(s) end menner steted.

29b. Signature end title of certifier: [signature]
29c. Licanse number: D28595
29d. Date signed (Month, Dey, Yeer): 2/11/01

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): YASNEEN LAKHANI, 7220 PARK HEIGHTS AVE BALTO MD 21208

State Registrar

31. Dete filed (Month, Dey, Yeer): FEB 13 2001
32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04038

Physician /Medical Examiner

1. Decedent's Nema *(First, Middla, Last)*: Joseph A Gardner
2. Data of Death — Month: Feb; Dey: 6; Yaar: 2001
3. Tima of Death: 8:10 AM
4a. Facility Nema *(If not institution, giva street and number)*: Howard County General Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Deeth: Howard

Funeral Director

5. Social Security Number: 213-34-9885
6. Sex: 1☒ M 2☐ F
7. Aga *(In yrs. last birthday)*: 65 Yrs.
If Under 1 Yaar — Months: ; Days:
If Under 24 Hrs. — Hours: ; Min.:
8. Data of Birth *(Month, Day, Yaar)*: 05-06-1935
9. Birthplace *(Stata or Foreign Country)*: Maryland

Usual Residence of Decedant

10a. State: MD.
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 6310 Tamar Drive
10f. Zip Code: 21045
10g. Citizan of Whet Country?: USA

11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Giva Yaar or Detas:
13. Was Decedant of Hispanic Origin? (Spacify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.): 1☐ Yes 2☒ No *Specify:*
14. Race - Amarican Indian, Black, White, etc. *Specify:* White

15. Decedant's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): ; Collega (1-4or 5+): 5±
16a. Decedent's Usuel Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Engineer
16b. Kind of Businass/Industry: NASA

17. Fathar's Nama *(First, Middla, Last)*: Joseph O. Gardner
18. Mothar's Nama *(First, Middla, Maidan Sumama)*: Clara Engelmeyer

19a. Informant's Name/Relationship *(Type, Print)*: Peggy Gardner - wife
19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 6310 Tamar Drive, Columbia, MD., 21045

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Nama of cematary, crametory or othar piece)*: Druid Ridge Cemetery
Data: 02-10-2001
20c. Location - City or Town, Stata: Pikesville, Maryland

21. Signature of Funeral Service Licensaa: Hanka L Lemmer 10074
22. Nama and Address of Facility: Witzke Funeral Home of Columbia, 5555 Twin Knolls Rd., Columbia, MD. 21045

Physician /Medical Examiner

23a. Part1. Enter the disaasa, or complications that causad tha death. Do not antar tha moda of dying, such as cardiac or respiratory errast, shock, or haart failura. List only ona causa on aach line.

Approximate Intarval Batwaen Onsat and Death

Immediata Causa (Final disaasa or condition resulting in daath)
a. Hepatic Failure — Dua to (or as a consequence of): — Month
b. Alcohol Abuse — Dua to (or as a consequence of): — 30yrs

Sequentially list conditions, if any, leading to immadiata causa. Enter Underlying Cause (Diseasa or injury that initiated events resulting in death) Last
c. — Dua to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying causa givan in Part I.: Acute Renal Failure, Coagulopathy; Metabolic Acidosis, Delerium Tremens; Alcohol Abuse

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Wara autopsy findings evallabla prior to complation of causa of daath? 1☐ Yes 2☒ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Placa of Daath *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Othar: 4☐ Nursing Home 5☐ Residance 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, tarm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledge, daath occurred at tha tima, data and plece, and dua to tha causa(s) end menner es stated. 2☐ **Medical Examiner:** On tha basis ot axamination and/or investigation, in my opinion, daath occurred et the tima, date and place, and due to tha cause(s) and mannar statad.

29b. Signature and title of certifier: MD
29c. Licanse number: 046120
29d. Data signed *(Month, Day, Year)*: Feb 6, 2001

30. Nama and addrass of person who completed causa of daath (Item 23a) (Type, Print): F Delcan 10724 Little Patuxent Pkwy, Columbia, MD 21044

State Registrar

31. Data filed *(Month, Day, Year)*: FEB 13 2001
32. Registrar's Signatura: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04039

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Raymond Kenneth Gundersdorff
2. Date of Death — Month: Feb. Day: 6 Year: 2001
3. Time of Death: 7:39 AM
4a. Facility Name *(If not institution, give street and number)*: St. Joseph's Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-36-0752
6. Sex: 1☐ M 2☐ F — X
7. Age *(In yrs. last birthday)*: 63 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 30 1937
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Glen Arm
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 13103 Dulaney Valley Rd.
10f. Zip Code: 21057
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: '55-'63
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales Representative
16b. Kind of Business/Industry: Electron Microscope

17. Father's Name *(First, Middle, Last)*: Edward Kenneth Gundersdorff
18. Mother's Name *(First, Middle, Maiden Surname)*: Ruth Matilda Mayhew

19a. Informant's Name/Relationship *(Type, Print)*: Thelma E. Gundersdorff/wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13103 Dulaney Valley Rd., Glen Arm, MD 21057

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Balto. Wash. Crematory — Date: 2/9/01
20c. Location - City or Town, State: Laurel, MD

21. Signature of Funeral Service Licensee: Bryan W. Clary
22. Name and Address of Facility: Lemmon Funeral Home, 10 W. Padonia Rd., Timonium, MD 21093

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Coronary Artery Disease
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Arteriosclerotic Cardio Vascular Disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Charles F O'Donnell MD
29c. License number: D-09383
29d. Date signed *(Month, Day, Year)*: February 7, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles F O'Donnell MD 111 Hamlet Hill Rd Baltimore MD 21210

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 13 2001
32. Registrar's Signature: Bernice G. Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04040

Mary Jean Green February 10, 2001 11:43 PM
Baltimore, Maryland 21215-0036

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Jean Green
2. Date of Death (Month, Day, Year): February 10, 2001
3. Time of Death: 11:43 PM
4e. Facility Name (If not institution, give street and number): Gilchrist Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 234-66-0536
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 60 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN 31, 1941
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1007 Quantril Way
10f. Zip Code: 21205
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Wallace Ramsey
18. Mother's Name (First, Middle, Maiden Surname): Marie Keith

19a. Informant's Name/Relationship (Type, Print): Johnny Green/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1007 Quantril Way Baltimore, MD 21205

20e. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.
Date: 2-12-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas Gregor
Thomas Gregor
22. Name and Address of Facility: Cremation Society of MD, Inc.
299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Breast Cancer — 16 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: W. Anthony Riley, MD
29c. License number: D25205
29d. Date signed (Month, Day, Year): February 11, 2001
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): W.A. Riley GBMC 6701 N. Charles St. Balto, Md 21204

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04041

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN MORRIS HARGRAVE
2. Dete of Deeth: Month February Dey 9 Yeer 2001
3. Time of Death: 6:55am
4a Facility Name (If not institution, give street and number): SINAI HOSPITAL ER
4b. City, Town, or Location of Deeth: BALTIMORE CITY
4c. County of Deeth: N/A

Funeral Director

5. Social Security Number: 243-20-3308
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Day, Year): OCT 9 1921
9. Birthplece (State or Foreign Country): NORTH CAROLINA

Usuel Residence of Decedent

10a. Stete: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 4017 LIBERTY HEIGHTS AVENUE
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A.
11. Maritel Status: 1 [ ] Never Married 2 [ ] Merried 3 [ ] Widowed 4 [X] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - Americen Indien, Black, White, etc. Specify: BLACK
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 3rd grade; College (1-4or 5+):
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): LABORER
16b. Kind of Business/Industry: BETHLEHAM STEEL
17. Fether's Neme (First, Middle, Last): LOUIS HARGRAVE
18. Mother's Name (First, Middle, Maiden Surname): CAMILLA SYKES
19e. Informent's Neme/Relationship (Type, Print): Mary E. Gray/ Careprovider
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3046 Grantley Avenue, Baltimore, Md., 21215
20e. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removel from State 4 [ ] Donetion 5 [X] Other (Specify) Entombment
20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS MEMORIAL PARK
Dete: 2-13-01
20c. Location - City or Town, Stete: BALTIMORE, MARYLAND
21. Signature of Funerel Service Licensee: Charles D. Powell
22. Name and Address of Fecility: WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet ceused the death. Do not enter the mode of dying, such es cerdiac or respiretory arrest, shock, or heart feilure. List only one ceuse on eech line.

Approximate Intervel Between Onset end Death

Immediete Cause (Final diseese or condition resulting in deeth)
a. Myocerdiel Infarction — 1day
Due to (or as a consequence of):
b. Coronary Artery Disease — 17y
Sequentiellty list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Lest
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
Stroke
Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings eveiteble prior to completion of ceuse of deeth? 1 [ ] Yes 2 [ ] No

25. Wes cese referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Deeth (Check only one): Hospital: 1 [ ] Inpetient 2 [ ] ER/Outpetient 3 [X] DOA. Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Menner of Deeth: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined
28a. Dete of Injury (Month, Day Yeer)
28b. Time of Injury
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) and menner es steted. 2 [ ] **Medical Examiner:** On the basis of exemineetion end/or investigetion, in my opinion, deeth occurred et the time, date and piece, end due to the cause(s) end menner steted.
29b. Signature and title of certifier: M Reyman MD
29c. License number: D25044
29d. Date signed (Month, Day, Year): 2/12/01
30. Neme end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print): M Reyman MD

State Registrar

31. Dete filed (Month, Day, Yeer): FEB 13 2001
32. Registrer's Signeture: Donna G Sparks

ORIGINAL

DHMH 16 Rev 6/95

To be Completed by Funeral Director

John Morris Hargrave
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

093

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2001 04042

Certificate of Death Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BARBARA HOLLIDAY
2. Date of Death Month Day Year: 02-11-2001
3. Time of Death: 11:15PM
4e. Facility Name *(If not institution, give street and number)*: 3603 FAIRVIEW AVENUE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 401-46-2157
6. Sex: 1☐M 2☒F
7. Age *(In yrs. last birthday)*: 92 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 02-10-1909
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10e. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 3603 FAIRVIEW AVENUE
10f. Zip Code: 21216
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* BLACK
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 5±
16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: TEACHER
16b. Kind of Business/Industry: EDUCATION
17. Father's Name *(First, Middle, Last)*: GEORGE MATTHEWS
18. Mother's Name *(First, Middle, Maiden Surname)*: LILLIE BRIGHT
19a. Interment's Name/Relationship *(Type, Print)*: BARBARA BARNES/NIECE
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3603 FAIRVIEW AVE., BALTO., MD 21216
20e. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GARDENS OF ETERNAL HOPE — Date: 2/15/2001 — 20c. Location - City or Town, State: FINKSburg, MD
21. Signature of Funeral Service Licensee: James A. Morton
22. Name and Address of Facility: JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST. BALTO., MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Cardiac Arrest
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Aortic Stenosis / Insufficiency
Due to (or as a consequence of):
c. Coronary Art. Disease
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*
27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Deborah A Mann MD
29c. License number: D50842
29d. Date signed *(Month, Day, Year)*: 2-13-01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 3100 Wyman Park Drive BALTO Md 21211 DeBorah Mann

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 13 2001
32. Registrar's Signature: D. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#13 perFHG792 2/13/2001 EW

Certificate of Death

Reg. No. 2001 04043

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Robert Calvin Hall	Feb. 10, 2001	6:00 AM

4a Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Stella Maris Hospice	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
112-28-4772	1 X M 2 F	53 Yrs.			April 4, 1947	New York

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	Baltimore	1 X Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
24 South Washington St	21231	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 X Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 X Yes 2 No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	Chef	Hospitality

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Quintin Eugene Hall	Julia Barraza

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Julia B. Blackman / mother	25105 Fir Ave Apt 106., Moreno Valley, CA 92553

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Chesapeake Crematory, Inc.	2/12/01	Beltsville, MD

21. Signature of Funeral Service Licensee: [signature] M00782

22. Name and Address of Facility: CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures DR., Towson, MD 21286

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Liver Failure	6 Weeks
Due to (or as a consequence of):	b. Hepatitis C	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 X No	1 Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 X No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature] MD	D 07930	February 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARVIN J. FELDMAN MD 301 St. Paul Place Baltimore, Md 21202

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 13 2001	[signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04044

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DOROTHY MAE HESSIE

2. Date of Death (Month, Day, Year): FEBRUARY 7 2001

3. Time of Death: 2:55 P.M.

4a. Facility Name (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL CENTER

4b. City, Town, or Location of Death: ROSEDALE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 212-30-6507

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Mar. 17, 1933

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore County

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8 DeCatur Rd.

10f. Zip Code: 21220

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th grade; College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Homemaking-Own Home

17. Father's Name (First, Middle, Last): Melburn Filmore Ewing

18. Mother's Name (First, Middle, Maiden Surname): Edna Mae Baker

19a. Informant's Name/Relationship (Type, Print): Mrs. Helen Koryto (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2405 Beverly Drive Joppa, Md. 21085

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holly Hill Me. Grdns. Date: 2-10-01

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: E. J. Lassahn

22. Name and Address of Facility: Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. ACUTE RESPIRATORY DISTRESS SYNDROME

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D 198911

29d. Date signed (Month, Day, Year): FEBRUARY 7, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HUZEFA BAHRAIN, MD. 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001

32. Registrar's Signature: for D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

HESSIE, DOROTHY

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

RKD

01-0708-005

JOHN HARROD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEMS# 23,ptII,27&28a-f per Certificate of Death

Reg. No. 2001 04045

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
JOHN HARROD	FEBRUARY 7, 2001	6:00P. M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
5100 DARIEN ROAD	ROSEDALE	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-30-9085	1☒M 2☐F	71 Yrs.			11-20-1929	WASHINTON, D.C.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	N/A	BALTIMORE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6027 BARSTOW RD.	21206	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Reca - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
-12-	-0-	PAINTER	PAINTING

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JOHN HARROD	MARY JACKSON

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
CORNELIA HARROD(DAUGHTER)	6027 BARSTOW RD. BALTIMORE, MARYLAND 21206

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	MT. ZION CEMETERY	2-13-2001	BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee ▶ Sarath D. Hibner

22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. HYPOTHERMIA (ENVIRONMENTAL EXPOSURE)	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or es e consequence of):	
	c. Due to (or es e consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) SCENE

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	found: 2-7-01	found: 6:00 PM	1☐Yes 2☒No	Environmental Exposure

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
found in woods	5100 Blk. Darien Rd, Rosedale, MD

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Dennis Chrisman	O.C.M.E.	FEBRUARY 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis Chrisman 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 13 2001	▶ Jeanne G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04046

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Frank Iczkowski
2. Data of Death — Month: February Day: 8 Yaar: 2001
3. Time of Death: 9:01 A.M.
4a Facility Name *(If not institution, giva street and number)*: Bon Secour Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217 09 1432
6. Sex: 1☒ M 2☐ F
7. Aga *(In yrs. last birthday)*: 81 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Yaar)*: Dec. 5, 1919
9. Birthplaca *(Stata or Foraign Country)*: Maryland

Usual Residenca of Decedent

10a. Stata: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Pasadena
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 7721 Middlegate Court
10f. Zip Code: 21122
10g. Citizan of Whet Country?: U.S.

11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedant Ever in U.S. Armed Forcas? 1☒ Yas 2☐ No — If Yas, Give Yaar or Datas: W.W. II
13. Was Dacedent of Hispanic Origin? (Spacify Yas or No- If Yas, specify Cuban, Maxicen, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*
14. Race - Amarican Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 5th — Collega (1-4or 5+):
16a. Decedent's Usual Occupetion *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Truck Driver
16b. Kind of Businass/Industry: Baltimore City

17. Fathar's Nama *(First, Middle, Last)*: Walter Iczkowski
18. Mothar's Nama *(First, Middla, Maidan Sumama)*: Alexandra Backa

19a. Informant's Name/Relationship *(Type, Print)*: Roberta Iczkowski / Wife
19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 7721 Middlegate Court Pasadena, Maryland 21122

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Nama of cematary, cramatory or othar place)*: Glen Haven Memorial Park
Data: 2/12/01
20c. Location - City or Town, Stata: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: Donna M Zramkowski
22. Nama and Addrass of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Entar tha disease, or complications that ceusad tha daath. Do not antar tha moda of dying, such as cerdiac or raspiratory arrast, shock, or heart failure. List only one ceusa on aach lina.

Approximata Interval Betwaen Onset end Death

Immediata Cause (Finat disease or condition resulting in death)
a. MYOCARDIAL INFARCTION — Sudden
Dua to (or as a consequance of):
Sequentiatly list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due lo (or as a consequance of):
c.
Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying causa givan in Part I.

23b. Dtd tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings availabla prior to complation of ceusa of daath? 1☐ Yas 2☒ No

25. Was cese refarred to medical examinar? 1☐ Yes 2☒ No

26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatiant 2☒ ER/Outpatient 3☐ DOA — Othar: 4☐ Nursing Homa 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datarmined

28a. Dete of Injury *(Month, Day Year)*
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Dascribe how injury occurred
28e. Plece of tnjury - At home, farm, straat, factory, office building, atc. *(Specify)*
28f. Location *(Street and Numbar or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurred at the time, dete end place, end dua to the cause(s) end manner as steted. 2☐ **Medical Examiner:** On tha basis of axamination and/or tnvastigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and mannar stated.

29b. Signatura and titla of certifier
29c. License number: D40491
29d. Data signed *(Month, Day, Yaar)*: February-11-2001

30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print): 800 N. Hammonds Ferry Rd Linthicum Md 21090

State Registrar

31. Data filed *(Month, Day, Yaar)*: FEB 13 2001
32. Registrar's Signatura

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.
To the Funeral Director: Aftar this certificata has been signed by the attending physician and completely filled in by the funeral director, paga 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04047

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Lizzie Jackson
2. Date of Death (Month, Day, Year): 02-10-2001
3. Time of Death: 6:28p.m.
4a. Facility Name (If not institution, give street and number): 2637 Loyola Southway 2nd. Fl.
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 218-22-6841
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 98 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 09-19-02
9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2637 Loyola Southway 2nd. Fl.
10f. Zip Code: 21215
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4th; College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Packer
16b. Kind of Business/Industry: Packing Company

17. Father's Name (First, Middle, Last): Samuel Braxton
18. Mother's Name (First, Middle, Maiden Surname): Alice Harvey

19a. Informant's Name/Relationship (Type, Print): Mary Johnson
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 826 Chauncey Avenue Baltimore, Maryland 21217

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Mt. Zion Bapt. Ch. Cem. Date: 02-15-01
20c. Location - City or Town, State: Red House, VA

21. Signature of Funeral Service Licensee: Francis O'Brien
22. Name and Address of Facility: March Funeral Home, East 1101 E. North Avenue Baltimore, MD 21202

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Hypertension
Due to (or as a consequence of): b. Peptic ulcer disease
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of): c. Alzheimer's disease
Due to (or as a consequence of): d. Cardio-pulmonary arrest

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D30115
29d. Date signed (Month, Day, Year): 2/12/1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): T. O'Hara Peraino MD 2600 Liberty Heights Ave Baltimore MD 21215

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#11 perFHG792 2/13/2001 EW

Certificate of Death

Reg. No. 2001 04048

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GERALDINE A. JESTER
2. Date of Death (Month, Day, Year): Feb. 7, 2001
3. Time of Death: 11:55 pm
4a. Facility Name (If not institution, give street and number): Good Samaritan N. Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-01-2819
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 6, 1919
9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 1601 E. Belvedere Avenue
10f. Zip Code: 21239
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DIETICIAN
16b. Kind of Business/Industry: Balto. City Hospital

17. Father's Name (First, Middle, Last): JAMES WHEATLEY
18. Mother's Name (First, Middle, Maiden Surname): MAE E. Downing

19a. Informant's Name/Relationship (Type, Print): HELEN JESTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1034 N. Washington St. Balto. Md 21205

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Mem. Pk | Date: 2/12/2001
20c. Location - City or Town, State: Arbutus, Md.

21. Signature of Funeral Service Licensee: Blanca Adams Jones
22. Name and Address of Facility: Marshall W. Jones, Jr. R.H. PA 410 Edmondson Ave. Balto. Md. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. ALZHEIMER'S DISEASE
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D16619
29d. Date signed (Month, Day, Year): February 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): E. VERGARA-SOARES 1601 E. BELVEDERE BALTIMORE, MD. 21239

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001
32. Registrar's Signature: Geneva B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04049

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BENJAMIN CLAYTON JARRELL
2. Date of Death (Month, Dey, Yeer): FEBRUARY 09, 2001
3. Time of Death: 10:30 PM
4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLENBURNIE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 213-30-4009
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 67 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): APR. 7, 1933
9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 1617 TIEMAN DRIVE
10f. Zip Code: 21061
10g. Citizen of Whet Country?: U.S.A.

11. Meritel Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedant Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates: 1953-1955
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)
Elementery/Secondery (0-12): 10
College (1-4or 5+):
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): MACHINIST
16b. Kind of Business/Industry: AEROSPACE

17. Fether's Neme (First, Middle, Last): NOAH B. JARRELL
18. Mother's Name (First, Middle, Meiden Surneme): EMMA FROST

19a. Informent's Name/Relationship (Type, Print): BEVERLY I. JARRELL (WIFE)
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 1617 TIEMAN DRIVE, GLEN BURNIE, MARYLAND 21061

20a. Method of Disposition: XX Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): MEADOWRIDGE MEMORIAL PARK
Date: 2/13/2001
20c. Location - City or Town, State: ELKRIDGE, MD

21. Signature of Funeral Service Licensee: [signature]
22. Neme and Addrass of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediate Ceuse (Final diseese or condition resulting in death)
a. HYPOXIC ENCEPHALOPATHY
Due to (or as a consequenca of):
b. CORONARY ARTERY DISEASE

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest
Due to (or es e consequenca of):
c.
Due to (or es e consequenca of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uee contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Deeth (Check only one): Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residenca 6 [ ] Other (Specify)
27. Menner of Deeth: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined
28a. Date of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) end menner es steted. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end placa, end due to the ceuse(s) end menner steted.
29b. Signeture end title of certifier: [signature] M.D.
29c. Licensa number: D51664
29d. Date signed (Month, Day, Yeer): FEBRUARY 09, 2001
30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): SUDHIR KUMAR AGGARWAL NORTH ARUNDEL HOSPITAL, 301 HOSPITAL DRIVE, GLEN BURNIE, MD 21061

State Registrar

31. Dete filed (Month, Dey, Yeer): FEB 13 2001
32. Registrar's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Jarrell Benjamin

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 12 per fh G792 2/13/01 yf

Certificate of Death

Reg. No: 2001 04050

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Data of Death Month / Day / Year	3. Tima of Death
Alexander		Karpinski	February 11 2001	4:07 AM

4a Facility Nama (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
The Johns Hopkins Hospital	Baltimore City	n/a

Funeral Director

5. Social Security Number	6. Sex	7. Aga (In yrs. last birthday)	If Under 1 Yaar: Months	If Under 1 Yaar: Days	If Under 24 Hrs.: Hours	If Under 24 Hrs.: Min.	8. Data of Birth (Month, Day, Yaar)	9. Birthplaca (State or Foreign Country)
217-26-3896	1☐M 2☐F	69 Yrs.					Feb. 21 1931	New York

Usual Rasidance of Decedant

10a. Stata	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Timonium	1☐Yas 2☒No

10e. Street and Number	10f. Zip Coda	10g. Citizen of What Country?
109 Belfast Rd.	21093	USA

11. Marital Status	12. Was Decedant Evar in U.S. Armed Forcas?	13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxicen, Puarto Rican, atc.)	14. Race - Amarican Indian, Black, Whita, atc.
1☐Navar Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yas 2☐No If Yas, Giva Yaar or Datas: '50-'59	1☐Yas 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired)	16b. Kind of Businass/Industry
Elementary/Secondary (0-12)	Collega (1-4or 5+)		
12	4	Telecommunications Executive	Telecommunications

17. Fathar's Nama (First, Middle, Last)	18. Mothar's Nama (First, Middle, Maiden Surname)
Alexander Karpinski	Elizabeth Toth

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Nancy Karpinski/daughter	247 Frontier Trail, Lusby, MD 20657

20a. Mathod of Disposition	20b. Place of Disposition (Name of cematary, cramatory or other placa)	Data	20c. Location - City or Town, Stata
1☒Burial 2☐Cramation 3☐Ramoval from Stata 4☐Donation 5☐Othar (Specify)	Dulaney Valley Memorial Gardens	2/14/01	Timonium, MD 21093

21. Signatura of Funaral Sarvica Licansaa	22. Nama and Addrass of Facility
Bryan W. Clary	Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only one causa on aach lina.

		Approximata Intarval Batwaan Onset and Death
Immediata Causa (Final disaasa or condition rasulting in daath)	a. Multiple Organ Failure Syndrome	2/8/01-2/11/01
	Dua to (or as a consaquanca of):	
Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaasa or injury that initiatad avants rasulting in daath) Last	b. Urosepsis	2/8/01-2/11/01
	Dua to (or as a consaquanca of):	
	c.	
	Dua to (or as a consaquanca of):	
	d.	

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contributa to the cause of death?	24a. Was an autopsy performed?	24b. Wara autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yas 2☒No	1☐Yas 2☐No

25. Was casa rafarrad to medical examinar?	26. Placa of Death (Check only one)	
1☐Yas 2☒No	Hospital: 1☒Inpatiant 2☐ER/Outpatiant 3☐DOA	Othar: 4☐Nursing Homa 5☐Rasidanca 6☐Othar (Specify)

27. Manner of Death	28a. Data of Injury (Month, Day Yaar)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accidant 3☐Suicida 4☐Homicida 5☐Pending invastigation 6☐Could not be datarmined		M	1☐Yas 2☐No	

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)	28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Cartifiar (Check only one) 1☒**Certifying Physician**: To tha best of my knowledga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐**Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at the tima, data and placa, and dua to tha cause(s) and mannar statad.

29b. Signatura and title of cartifiar	29c. Licansa number	29d. Data signed (Month, Day, Yaar)
M.D.	RES-000	2/11/01

30. Nama and addrass of parson who complatad causa of daath (Item 23a) (Type, Print)

Paul Robert Forfia, Johns Hopkins Hospital, 600 N. Wolfe Street, Baltimore MD

State Registrar

31. Data filad (Month, Day, Yaar)	32. Registrar's Signatura
FEB 13 2001	Penelope D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after daath with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04051

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James C. Long
2. Date of Death (Month, Day, Year): 2/7/2001
3. Time of Death: 4:30 PM
4a. Facility Name (If not institution, give street and number): 12510 Harford Rd
4b. City, Town, or Location of Death: Hydes
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 230-20-6792
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 7/19/1926
9. Birthplace (State or Foreign Country): Danville, VA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Hydes
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 12510 Harford Rd.
10f. Zip Code: 21082
10g. Citizen of What Country?: USA
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years | College (1-4or 5+): 4 years
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Claims Adjuster
16b. Kind of Business/Industry: Auto Repair Industry
17. Father's Name (First, Middle, Last): Eury Long
18. Mother's Name (First, Middle, Maiden Surname): Lizzie Mann
19a. Informant's Name/Relationship (Type, Print): Dolores Long (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12510 Harford Rd. Hydes, MD 21082
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Moreland Cemetery
Date: 2/12/2001
20c. Location - City or Town, State: Parkville, MD
21. Signature of Funeral Service Licensee: E.F. Lassahn
22. Name and Address of Facility: E.F.Lassahn Funeral Home 11750 Belair Rd Kingsville, Md 21087

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	LUNG CANCER	6 MOS.
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.		
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: G.I.C.
29c. License number: D27730
29d. Date signed (Month, Day, Year): 2/8/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): GARY COHEN, MD 6569 N. CHARLES ST. BALTIMORE, MD 21204

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001
32. Registrar's Signature: D. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

230-20-6792 ^ 14 11/13/1920 Alexandria, VA

X

MD Baltimore Hydes

12510 Harford Rd. 21082 USA

X X WWII X white

12 years 4 years Claims Adjuster Auto Repair Industry

Eury Long Lizzie Mann

Dolores Long (wife) 12510 Harford Rd. Hydes, MD 21082

X

Moreland Cemetery 2/12/2000 Parkville, MD

E.F.Lassahn Funeral Home
11750 Belair Rd Kingsville, Md 21087

Lane Carter 6 Nov.

01-0587-510
crn
Leonard T. William

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND#8 PER F.H.G792 2-13-2001 JAB

Certificate of Death

2001 04052
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM T. LEONARD
2. Date of Death (Month, Day, Year): February 02, 2001
3. Time of Death: 10:40 PM
4a. Facility Name (If not institution, give street and number): 2206 Etting Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-80-1589
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 40 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 1-25-61 ~~2-2-2001~~
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 X Yes 2 ☐ No
10e. Street and Number: 1715 DRUID HILL AVENUE
10f. Zip Code: 21217
10g. Citizen of What Country? USA

11. Marital Status: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 11th
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER
16b. Kind of Business/Industry: CONTRUCTION

17. Father's Name (First, Middle, Last): WALTER A. LEONARD
18. Mother's Name (First, Middle, Maiden Surname): MARY M. JOHNSON

19a. Informant's Name/Relationship (Type, Print): MARY HODGE/MOTHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8711 MEADOW HEIGHTS RD, RANDALLSTOWN, MD 21133

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): KING MEM. PARK
Date: 2/15/2001
20c. Location - City or Town, State: RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: HARI P. CLOSE FUNERAL SERVICE, P.A 709 TESSIER STREET BALTIMORE, MD 21201-1925

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Hypertensive Arteriosclerotic Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Was an autopsy performed? 1 X Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 X Yes 2 ☐ No

25. Was case referred to medical examiner? 1 X Yes 2 ☐ No

28. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) at scene

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury: M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Margarita Korell
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): February 03, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04053

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elaine Lacey
2. Data of Death Month Day Year: 02 - 09 - 01
3. Time of Death: 6:15pm
4a. Facility Name (If not institution, give street and number): University of Maryland Medical Center
4b. City, Town, or Location of Death: Baltimore, Maryland
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 196-34-5886
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 57 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): FEB 8, 1944
9. Birthplace (State or Foraign Country): Pennsylvania

Usual Rasidance of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Insida City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1111 Park Avenue Apt #1110
10f. Zip Coda: 21201
10g. Citizan of What Country?: USA

11. Maritel Status: 1☐ Nevar Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Dacadent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Give Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:
14. Raca - Amarican Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highast grada complatad)
Etamantary/Secondary (0-12):
Collega (1-4or 5+): 5 +
16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): Social Security Administration
16b. Kind of Businass/Industry: Federal Government

17. Fathar's Nama (First, Middla, Last): Oscar T. Hahn
18. Mothar's Nama (First, Middla, Maidan Sumama): Levena Faust

19a. Informant's Nama/Ralationship (Type, Print): Oscar Hahn/Brother
19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 204 Maple Street Danville, PA 17821-1316

20a. Mathod of Disposition: 1☐ Burial 2☒ Cremation 3☐ Ramoval from Stata 4☐ Donetion 5☐ Othar (Specify)
20b. Placa of Disposition (Nama of cemetary, cramatory or othar placa): Metro Crematory Inc.
Data: 2-12-01
20c. Location - City or Town, Stata: Baltimore, MD

21. Signatura of Funeral Sarvica Licensee: Thomas Gregor
22. Name and Addrass of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that causad tha deeth. Do not antar tha moda of dying, such as cardiac or raspiratory errast, shock, or haart faitura. List only ona causa on aach lina.

Approximate Intarval Batween Onset and Death

Immediata Causa (Final diseasa or condition resulting in death)
a. End-Stage Renal Disease — 3 mos
Dua to (or as a consaquanca of):
b. Cardiac Arrhythmia — 3 mos
Dua to (or as a consequanca of):

Sequentially list conditions, if any, laading to immedieta cause. Entar Underlying Causa (Disaasa or injury that initiated events resulting in daath) Last
c.
Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

23b. Did tobacco uae contribute to the cauae of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion of cause of daath? 1☐ Yes 2☒ No

25. Was casa rafarrad to medical examiner? 1☐ Yas 2☒ No

26. Placa of Death (Check only ona)
Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA
Othar: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifiar (Check only one): 1☒ **Certifying Physician**: To tha best of my knowladga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar stated.

29b. Signeture and title of certifier: Naidi Feinberg
29c. Licansa number: P14701
29d. Data signad (Month, Day, Year): 02-09-01

30. Name and addrass of person who complatad causa of daath (Item 23a) (Type, Print): Naidi Feinberg University of Maryland 22 S. Greene Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Year): FEB 13 2001
32. Registrar's Signatura: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04054

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Trudy McCraw

2. Date of Death: Month 2 Day 3 Year 2001

3. Time of Death: 12:15 PM

4a. Facility Name (If not institution, give street and number): Rustow

4b. City, Town, or Location of Death: Baltimore Md

4c. County of Death:

Funeral Director

5. Social Security Number: 230-22-4990

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 100 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): APRIL 17, 1900

9. Birthplace (State or Foreign Country): GEORGIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: BALTIMORE

10c. City, Town or Location: PIKESVILLE

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 4127 BALMOREL CIRCLE

10f. Zip Code: 21208

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 6

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: PRIVATE

17. Father's Name (First, Middle, Last): WILL McCRAW

18. Mother's Name (First, Middle, Maiden Surname): PRISCILLA PEOPLES

19a. Informant's Name/Relationship (Type, Print): THELMA SMITH / NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21208: 4127 BALMOREL CIRCLE PIKESVILLE, MD

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): King Park Cemetery

Date: 2/10/01

20c. Location - City or Town, State: RANDALLSTOWN, MARYLAND

21. Signature of Funeral Service Licensee: Vaughn C Greene

22. Name and Address of Facility: VAUGHN C. GREENE Funeral Service 5151 Balto. Nat'l Pike Balto. MD. 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Alzheimers — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

peripheral vascular disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D37573

29d. Date signed (Month, Day, Year): Feb 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jef Zibell MD 25 Main St. Reisterstown MD 21136

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001

32. Registrar's Signature: Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04055

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Margaret McKinney
2. Date of Death (Month, Day, Year): February 9 2001
3. Time of Death: 0152pm
4a. Facility Name *(If not institution, give street and number)*: St. Agnes Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 251-48-0396
6. Sex: 1☐ M 2☑ F
7. Age *(In yrs. last birthday)*: 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 1-21-1934
9. Birthplace *(State or Foreign Country)*: SC

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 35 S. Kossuth St.
10f. Zip Code: 21229
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th Grade | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: House wife
16b. Kind of Business/Industry: Domestic
17. Father's Name *(First, Middle, Last)*: Norman Griffin
18. Mother's Name *(First, Middle, Maidan Surname)*: Sarah Mulligan
19a. Informant's Name/Relationship *(Type, Print)*: Samuel McKinney (husband)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 35 S Kossuth st. Balto. MD. 21229
20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Arbutus Cemetery
Date: 2/14/01
20c. Location - City or Town, State: Balto., MD.
21. Signature of Funeral Service Licensee: Vaughn C Greene
22. Name and Address of Facility: Vaughn C Greene Funeral Services 5151 Balto. Nat'l Pike Balto. MD. 21229

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Atherosclerotic Cardiovascular Disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Margaret R McKinney
Division of Vital Records, P.O. Box 68760,

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Attending Physician
29c. License number: D51853
29d. Date signed *(Month, Day, Year)*: February 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Silverman 900 Caton Avenue Baltimore 21229

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 13 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04056

EMILY MILLER

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Emily Miller

2. Dete of Deeth Month: 02 Day: 07 Yeer: 01

3. Time of Death: 8:40P

4e Fecility Neme *(If not institution, give street end number)*: Millenium Nursing Home

4b. City, Town, or Location of Deeth: Baltimore

4c. County of Deeth: N/A

Funeral Director

5. Social Security Number: 223-34-2062

6. Sex: 1☐ M 2☒ F XX

7. Age *(In yrs. last birthday)*: 79 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: Jan. 13, 1922

9. Birthplece *(Stete or Foreign Country)*: North Carolina

To Be Completed by Funeral Director

Usuel Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No XX

10e. Street end Number: 3217 Vickers Road

10f. Zip Code: 21216

10g. Citizen of Whet Country?: USA

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed X 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates: X

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indien, Bleck, White, etc. *Specify:* Black

15. Decedent's Educetion *(Specify only highest grade completed)*

Elementery/Secondary (0-12): 7th grade

College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Presser

16b. Kind of Business/Industry: Misty Harbor

17. Father's Name *(First, Middle, Last)*: Martin Nichols

18. Mother's Name *(First, Middle, Maiden Sumeme)*: Nora Moore

19a. Informent's Name/Relationship *(Type, Print)*: Alvina Miller /Daughter

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 3217 Vickers Road Baltimore, Maryland 21216

20a. Method of Disposition: 1☒ Buriat 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piace)*: Arbutus Memorial Park

Dete: 2/12/2001

20c. Location - City or Town, Stete: Arbutus, Maryland

21. Signeture of Funeral Service Licensee: Stacy Harris

22. Neme end Address of Facility: Chatman-Harris Funeral Home 5240 Reisterstown Road baltimore, Maryland 21215

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximate Intervel Between Onset end Death

Immediate Ceuse (Finel disease or condition resulting in deeth)

a. Pneumonia — 1 month

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest

b. Dementia of Alzheimer's type — 10 Yrs

Due to (or es e consequence of):

c.

Due to (or as a consequence of):

d.

Pert II. **Other signifiicent conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 1☐ Yes 2☒ No

25. Was case referred to medicel exeminer? 1☐ Yes 2☒ No

26. Piece of Death *(Check only one)*

Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Exeminer:** On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner steted.

29b. Signeture end title of certifier: Micro-D Kirurg, MD

29c. License number: 031865

29d. Date signed *(Month, Day, Yeer)*: 2/9/01

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): RM 206 821 N Curtain street Baltimore Md 2/201

State Registrar

31. Date filed *(Month, Day, Yeer)*: FEB 13 2001

32. Registrer's Signeture: G. Spaeth

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04057

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DOROTHY LOUISE MORRIS

2. Date of Death: Month February Day 5 Year 2001

3. Time of Death: 1642 pm

4a. Facility Name (If not institution, give street and number): Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-84-7491

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 39 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): SEPT 10 1961

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2872 W. BALTIMORE STREET

10f. Zip Code: 21223

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MAIL SORTER

16b. Kind of Business/Industry: ADVANCE PRE-SORT

17. Father's Name (First, Middle, Last): FRANK JAMES MORRIS

18. Mother's Name (First, Middle, Maiden Surname): ALVA WELLBORN

19a. Informant's Name/Relationship (Type, Print): ALVA MORRIS/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2872 W. Baltimore St., Baltimore Md., 21223

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): LOUDON PARK

Date: 2-14-01

20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Charles F. Bowie

22. Name and Address of Facility: WILLIAM C BROWN COMMUNITY FUNERAL HOME PA
1206 W NORTH AVENUE

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Metabolic Acidosis, Human immunodeficiency Virus +

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: P14574

29d. Date signed (Month, Day, Year): 2/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Woodward Dixon, JR. M.D. To Maryland General Hospital

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001

32. Registrar's Signature:

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Dorothy Morris

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04058

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Leonard Middleton

2. Date of Death: Month Feb Day 7 Year 2001

3. Time of Death: 0815

4a. Facility Name (If not institution, give street and number): St. Agnes Hospital

4b. City, Town, or Location of Death: Baltimore MD

4c. County of Death: NA

Funeral Director

5. Social Security Number: 218-60-7281

6. Sex: 1 X M 2 ☐ F

7. Age (In yrs. last birthday): 48 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 09 11 52

9. Birthplace (State or Foreign Country): N.Y.

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 X Yes 2 ☐ No

10e. Street and Number: 2 South Rosedale Street

10f. Zip Code: 21229

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th grade

College (1-4or 5+): na

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Auto Mechanic

16b. Kind of Business/Industry: Auto Shop

17. Father's Name (First, Middle, Last): John Middleton Sr.

18. Mother's Name (First, Middle, Maiden Surname): Mary L. Fitzgerald

19a. Informant's Name/Relationship (Type, Print): Deborah Middleton-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2 South Rosedale Street, Baltimore Md 21229

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): King Memorial Park

Date: 2/13/01

20c. Location - City or Town, State: Randallstown, Md

21. Signature of Funeral Service Licensee: Glynis B Keke

22. Name and Address of Facility: March F/H West, 4300 Wabash Ave, Baltimore, Maryland 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. METABOLIC ACIDOSIS — DAYS

Due to (or as a consequence of):

b. RENAL FAILURE — MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HUMAN IMMUNO-DEFICIENCY VIRUS INFECTION /ACQUIRED IMMUNE DEFICIENCY SYNDROME

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 X No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☑ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: M. Keaser M.D.

29c. License number: P13601

29d. Date signed (Month, Day, Year): 2-7-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NANA CEASAR ; ST AGNES HOSPITAL ; 900 CATON AVENUE, BALTIMORE MD 21229

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

NAME Middleton, Leonard

Division of Vital Records, P.O. Box 68760,

RKD

01-0790-510

DORIS MARTIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04059

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Doris Jean Martin
2. Date of Death (Month, Day, Year): FEBRUARY 11, 2001
3. Time of Death: 6:00P. M
4a. Facility Name (If not institution, give street and number): 1701 EDMONDSON AVE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 220-20-4351
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11-13-1925
9. Birthplace (State or Foreign Country): Md

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1701 Edmondson Avenue
10f. Zip Code: 21223
10g. Citizen of What Country?: U S A

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th grade
College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nursing Supervisor
16b. Kind of Business/Industry: Rosewood State Hospital

17. Father's Name (First, Middle, Last): John Henry Brown
18. Mother's Name (First, Middle, Maiden Surname): Edith Kent

19a. Informant's Name/Relationship (Type, Print): Bruce Martin- Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1721 Westwood Avenue Baltimore, Md

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory
Date: 2-13-2001
20c. Location - City or Town, State: Catonsville, Md

21. Signature of Funeral Service Licensee: Dale March
22. Name and Address of Facility: March F/H West 4300 Wabash Avenue Baltimore, Md 21215

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

28. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): FEBRUARY 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID R. FOWLER M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001
32. Registrar's Signature: Jeanne B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04060

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Maude D Matthews

2. Date of Death (Month, Day, Year): 02 - 12 - 2001

3. Time of Death: 4:45 AM

4a. Facility Name (If not institution, give street and number): The Wesley Home 2211 W. Rogers Avenue

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-24-4122

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 29, 1905

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: The Wesley Home 2211 W, Rogers Ave.

10f. Zip Code: 21209

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Robert Lewis

18. Mother's Name (First, Middle, Maiden Surname): Ella T. Taylor

19a. Informent's Name/Relationship (Type, Print): Wilma Wehrle Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): PO Box 128 Cottage 702 A. Wesley Drive Quincy, PA 17247

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore-Washington Crematory

Date: 2/13/01

20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: Lynn B. Henss

22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. END-STAGE CONGESTIVE HEART FAILURE — WEEKS

Due to (or as a consequence of):

b. CONGESTIVE CARDIOMYOPATHY — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — YEARS

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

RENAL INSUFFICIENCY, ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert E. Roby M.D.

29c. License number: D-19425

29d. Date signed (Month, Day, Year): 2-12-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT E. ROBY, M.D. - 2211 W. ROGERS AVE - BALTO., MD 21209

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

MAUDE MATTHEWS

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04061

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dorothy M Millham

2. Data of Death — Month: 02 Day: 08 Yaar: 01

3. Tima of Death: 2:30pm

4a. Facility Nama *(If not institution, giva street and number)*: Harbor Hospital

4b. City, Town, or Location of Daath: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Numbar: 566-40-3605

6. Sex: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 75 Yrs.

If Undar 1 Yaar — Months: Days:

If Undar 24 Hrs. — Hours: Min.:

8. Data of Birth *(Month, Day, Yaar)*: May 26, 2001

9. Birthplaca *(Stata or Foraign Country)*: Newfoundland

Usual Rasidance of Dacadant

10a. Steta: MD

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Numbar: 6430 Polk Circle

10f. Zip Coda: 21061

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Navar Marriad 2☐ Marriad 3☐ Widowad 4☒ Divorcad

12. Was Decadant Evar in U.S. Armad Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Dacadant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Raca - Amarican Indian, Black, Whita, atc. *Specify:* White

15. Decadant's Education *(Specify only highast grada compliatad)*: Elamantary/Sacondary (0-12): College (1-4or 5+): 4

16a. Decadant's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT usa retirad)*: Social Worker

16b. Kind of Businass/Industry: MD State

17. Fathar's Nama *(First, Middla, Last)*: James M. Atkinson

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Bridget A. Connoly

19a. Informant's Nama/Ralationship *(Typa, Print)*: Cheryl Thome

19b. Mailing Addrass *(Street and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Coda)*: 3421 Pierce Drive, Ellicott City, MD 21042

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of camatary, cramatory or othar placa)*: Chesapeake Cremation

Data: 2/11/01

20c. Location - City or Town, Stata: Stevensville, MD

21. Signatura of Funaral Sarvica Licansaa: Mazza

22. Nama and Addrass of Facility: Singleton Funeral Home 1 Second Ave Glen Burnie Maryland 21061

Physician /Medical Examiner

23a. Part I. Entar the disaasa, or complications that causad the death. Do not entar the moda of dying, such as cardiac or raspiratory arrast, shock, or hart failura. List only ona ceusa on aach lina.

Approximata Intarval Batwaan Onsat and Death

Immadiata Cause (Final disaasa or condition rasulting in daath)
e. Acute Myocardial Infarction — 1 Day

Due to (or as a consequanca of):
b. Coronary Artery Disease — 6 Months

Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disaasa or injury that initiatad avants rasulting in daath) Last
Due to (or as a consequanca of):
c. Carcinoma of Breast — 5 Months

Due to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performad? 1☐ Yas 2☒ No

24b. Were autopsy findings availabla prior to compiation of causa of daath? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No

28. Placa of Death *(Chack only ona)*: Hospital: 1☐ Inpatiant 2☒ ER/Outpatiant 3☐ DOA Othar: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Othar *(Specify)*

27. Mannar of Daath: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding Invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Yaer)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurrad

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Spacify)*

28f. Location *(Straat and Numbar or Rural Routa Numbar, City or Town, Stata)*

29a. Cartifier *(Check only one)*: 1☒ **Cartifying Phyaician**: To the bast of my knowladga, death occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as statad. 2☐ **Medical Examinar**: On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha cause(s) and mannar statad.

29b. Signatura and title of cartifiar: Whynae MD Attending Doctor

29c. Licansa number: D21684

29d. Data signad *(Month, Day, Yaer)*: 2-09-01

30. Nama and addrass of parson who completad causa of daath (Item 23a) (Type, Print): C.V. CYRIAC M.D 8021 RITCHIE HWY, PASADENA, MD 21122

State Registrar

31. Data filad *(Month, Day, Yaar)*: FEB 13 2001

32. Registrar's Signatura: Geneva D. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha daath cartificata be axacutad within 24 hours after daath.
To the Funeral Director: Aftar this cartificata has been signad by tha attanding physician and completely filled in by tha funaral director, paga 2 should be datachad for usa as the burial-transit

H

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 04062

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN M MORAN, SR.
2. Date of Death (Month, Day, Year): FEBRUARY 10, 2001
3. Time of Death: 12:15 P.M

4a. Facility Name (If not institution, give street and number): Dulaney-Towson Health Care
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-42-4651
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 57 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 9, 1944
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Mount Washington
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2 Sunny Meadow Court Apt 201
10f. Zip Code: 21209
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Factory Worker
18b. Kind of Business/Industry: Spring Manufacturing

17. Father's Name (First, Middle, Last): Lyeth Harold Moran
18. Mother's Name (First, Middle, Maiden Surname): Norma Catherine Smith

19a. Informant's Name/Relationship (Type, Print): John M. Moran, Jr. Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2 Sunny Meadow Court Apt 201 Baltimore, Md 21209

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore-Washington
Date: 2/12/2001
20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: Lynn B. Henss
22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc 21211
3631 Falls Road, Baltimore, Maryland

Physician /Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE Gastra Intestinal Bleed — 2 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. Metastatic Skin Carcinoma — 9 years
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

28. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [illegible] Attending Physician
29c. License number: D53642
29d. Date signed (Month, Day, Year): Feb 12 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): [illegible] 3007 E. Northern Parkway Baltimore 21214

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001
32. Registrar's Signature: [illegible]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04063

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MAry J. Nowottnick

2. Date of Death (Month, Day, Year): FEBRUARY 11 2001

3. Time of Death: 5-00 PM

4a. Facility Name (If not institution, give street and number): North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 175-20-7805

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 7/9/1915

9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: ☒ Yes 2☐ No

10e. Street and Number: 2823 Florida Avenue

10f. Zip Code: 21227

10g. Citizen of Whet Country?: USA

11. Meritel Status: 1☐ Never Married ☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Americen Indian, Black, White, etc. Specify: white

15. Decedent's Eduction (Specify only highest grade completed): Elementary/Secondery (0-12): 7 | College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Wireman/assembly

16b. Kind of Business/Industry: Westinghouse

17. Father's Name (First, Middle, Last): William R. Kunkel, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Ellen V. McGowan

19a. Informant's Name/Relationship (Type, Print): Marjorie Bailey - daug.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 435 Arbor Drive, Glen Burnie, MD 21061

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Glen Haven Cemetery

Date: 2/14

20c. Location - City or Town, State: Glen Burnie, MD

21. Signature of Funeral Service Licensee: Kelly Gregory Fink

22. Name and Address of Facility: Fink Funeral Home, PA
426 Crain Hwy., SW, Glen Burnie, MD 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Deeth
Immediate Cause (Final disease or condition resulting in death) a.	ACUTE MYOCARDIAL INFARCTION	1 HOUR
Due to (or es e consequence of): b.	ACUTE PNEUMONIA	4 DAYS
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of ceuse of deeth? 1☐ Yes 2☒ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signeture end title of certifier: MD

29c. License number: D 46962

29d. Date signed (Month, Day, Year): FEBRUARY 11, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): M. SHIRAZI, M.D. NORTH ARUNDEL HOSPITAL. MD 21061.

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Nowottnick, Mary
Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04064

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Hong Viet Nguyen
2. Data of Death Month: Feb. Day: 4 Year: 2001
3. Time of Death: 9:20 AM
4a Facility Name *(If not institution, give street and number)*: Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 213-55-2788
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 43 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 29, 1957
9. Birthplace *(State or Foreign Country)*: Vietnam

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George
10c. City, Town or Location: Riverdale
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 6219 Fernwood Terrace #201
10f. Zip Code: 20737
10g. Citizen of What Country?: Vietnam

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Asian

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Electrician
16b. Kind of Business/Industry: Electric Company

17. Father's Name *(First, Middle, Last)*: Qui Hong Nguyen
18. Mother's Name *(First, Middle, Maiden Surnama)*: Tien Thi Vu

19a. Informant's Name/Relationship *(Type, Print)*: Phu Chau Thi Nguyen/Spouse
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6219 Fernwood Terrace #201, Riverdale, MD 20737

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Placa of Disposition *(Name of cemetery, crematory or other place)*: National Crematory — Date: 2-10-01
20c. Location - City or Town, State: Falls Church, VA

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: National Funeral Home 7482 Lee Highway, Falls Church, VA 22042

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Lung Cancer — 15 Months

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as e consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examinar? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Othar: 4 [ ] Nursing Home 5 [ ] Residenca 8 [ ] Other *(Spacify)*

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Data of Injury *(Month, Dey Year)*
28b. Tima of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] M.D
29c. License number: D41828
29d. Date signed *(Month, Day, Year)*: Feb. 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Clara Chan, M.D., 9801 Georgia Ave. #337, Silver Spring, MD 20902

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 13 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04065

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
LIZA	OLSHANSKY	February 8, 2001	4:50 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sinai Hospital of Baltimore	Baltimore City	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-94-3117	1 ☐ M 2 ☒ F	76 Yrs.			APR. 17, 1924	UKRAINE

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1 ☒ Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5715 PARK HEIGHTS AVENUE #514	21215	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		CLERK	MEDICAL RECORDS

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
ELCHON	GRUBMAN	CHAYA	SMOLENSKYA

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
IZYA OLSHANSKY / HUSBAND	5715 PARK HEIGHTS AVENUE #514 - BALTIMORE, MD 21215

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ARLINGTON CHIZUK AMUNO	2/11/01	BALTIMORE, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Robert Levinson	SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. cerebrovascular accident	2 days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Myocardial infarction

Non-Hodgkin's lymphoma

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 ☐ Yes 2 ☒ No	Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Malka Blass, MD	RES000	February 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Malka BLASS 2401 West Belvedere Avenue Baltimore, Maryland

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 13 2001	▶ Bonnie B Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

LIZA OLSHANSKY
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04066

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Gladys Alma Preble

2. Data of Death — Month: Feb. Day: 12 Year: 2001

3. Time of Death: 7:55 am.

4a. Facility Name *(If not institution, give street and number)*: 1681 East Mayberry Rd.

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 212-05-6227

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 90 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Jan. 8, 1911

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1681 East Mayberry Rd.

10f. Zip Code: 21158

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Waitress

16b. Kind of Business/Industry: Restaurant

17. Father's Name *(First, Middle, Last)*: Charles Louis Wittbecker

18. Mother's Name *(First, Middle, Maiden Surname)*: Alberta Mae Green

19a. Informant's Name/Relationship *(Type, Print)*: Leslie James Preble - Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1681 East Mayberry Rd., Westminster, Md. 21158

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Garden of Faith Cem. Data: Feb. 15, 2001

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: H.A. Eckhardt

22. Name and Address of Facility: Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, Md. 21117

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. LUNG CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Craig G. Haber MD

29c. Licensa number: D24866

29d. Data signed *(Month, Day, Year)*: 02-12-01

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): Craig G. HABER MD 210 Business Center Dr, Reisterstwn 21136

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 13 2001

32. Registrar's Signature: Barbara G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04067

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Florence Palmer
2. Date of Death (Month, Day, Year): Feb. 11, 2001
3. Time of Death: 01:20AM
4a. Facility Name (If not institution, give street and number): 3812 Leadenhall St
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 143-20-9461
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 20, 1927
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3812 Leadenhall St
10f. Zip Code: 21230
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): (Unknown) Centalonza
18. Mother's Name (First, Middle, Maiden Surname): (Unknown) (Unknown)

19a. Informant's Name/Relationship (Type, Print): Louis Palmer / husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3812 Leadenhall St., Baltimore, MD 21230

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory, Inc. | Date: 02/13/01
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: ▶ Laura C. Hendrickson
22. Name and Address of Facility: CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures DR., Towson, MD 21286

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
e. Myocardial Infarction

Due to (or as a consequence of):
b. Coronary Artery Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Hypertension

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Anita Khandelwal MD
29c. License number: D0052490
29d. Date signed (Month, Day, Year): 2/12/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Anita Khandelwal MD 3001, S. Hanover St. # 405 Baltimore MD 21225

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001
32. Registrar's Signature: ▶ Geneva D. Sparks

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 29c,29d per Dr.,G792,02/14/01dnb

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04068

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day	Year	3. Time of Death
ANTHONY	PICCININI	JANUARY	27	2001	4:20PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
JOHNS HOPKINS BAYVIEW MEDICAL CENTER	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-05-4418	1☒ M 2☐ F	80 Yrs.					Feb 7 1920	Italy

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Baltimore	Towson	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
621 St. Francis Rd.	21286	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Realtor & Developer	Real Estate

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Caesar Piccinini	Rosa Laudi

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mr. Charles Piccinini/ Son	111 N.Charles St. #300 Baltimore, Md. 21201

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) Entombment	Dulaney Valley Mem.	1-31-01	Timonium, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Kent J. Young	Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE RESPIRATORY DISTRESS SYNDROME	4 WEEKS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Kenneth C. Bilchick, MD	RES-000	January 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
KENNETH BILCHICK, MD TOWER 110 - JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21287

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 13 2001	▶ Lenore D. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

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ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04069

PATTEN, Doris

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Doris PATTEN

2. Date of Death — Month: FEb. Day: 12 Year: 01

3. Time of Death: 12:30AM

4a. Facility Name (If not institution, give street and number): St. Elizabeth Nursing Home

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 212-07-0648

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 12, 1918

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3320 Benson Avenue

10f. Zip Code: 21227

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Henry Clayton Poffenberger

18. Mother's Name (First, Middle, Maiden Surname): Florence Kiel

19a. Informant's Name/Relationship (Type, Print): Carol Patten-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7848 Cornerstone Way, Baltimore, Maryland 21244

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mountain View Cemetery

Date: 02/14 2001

20c. Location - City or Town, State: Sharpsburg, Maryland

21. Signature of Funeral Service Licensee: Debra McDavis

22. Name and Address of Facility: Witzke Funeral Home of Catonsville, 1630 Edmondson Avenue, Catonsville, Maryland21228

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. RECURRENT CEREBROVASCULAR ACCIDENT — 3 weeks

Due to (or as a consequence of):
b. CEREBROVASCULAR INSUFFICIENCY — 10 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
PREVIOUS CEREBROVASCULAR ACCIDENTS, CORONARY HEART DISEASE. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ATTENDING PHYSICIAN

29c. License number: D16200

29d. Date signed (Month, Day, Year): February 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NORBERTO. M. MACHIRAN, MD. 720-C MAIDEN CHOICE LA. BALTO. MD. 21228

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001

32. Registrar's Signature: Jennifer B Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04070

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William George Pero, Sr.

2. Date of Death: Month 02 Day 10 Year 2001

3. Time of Death: 4:46 AM

4a. Facility Name (If not institution, give street and number): Laurel Regional Hospital

4b. City, Town, or Location of Death: Laurel

4c. County of Death: P.G.

Funeral Director

5. Social Security Number: 154-07-3990

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 07-06-1922

9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: MD.

10b. County: P.G.

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 14110 Bramble Court Apt. 103

10f. Zip Code: 20707

10g. Citizen of Whet Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NSA Administrator

16b. Kind of Business/Industry: NSA

17. Father's Name (First, Middle, Last): Steven Pero

18. Mother's Name (First, Middle, Maiden Surname): Ann Borsovic

19a. Informant's Name/Relationship (Type, Print): Rose Seybuck - Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19 Norwalk Avenue, Whiting, New Jersey, 08759

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore Wash., Cremetory 2001 | Date: 02-17

20c. Location - City or Town, State: Laurel, MD.

21. Signature of Funeral Service Licensee: Debbie M Davis

22. Name and Address of Facility: Fleck Funeral Home 7601 Sandy Spring Rd., Laurel, MD., 20707

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Upper massive gastrointestinal bleeding — hours

Due to (or as a consequenca of):

b. Cirrhosis

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequenca of):

c. Chronic Liver disease

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HTN

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of causa of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residenca 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): [X] 1 **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the cause(s) end menner es steted. 2 [ ] **Medical Examiner:** On the basis of examination and/or invastigation, in my opinion, death occurred et the time, date end plece, end due to the cause(s) end manner stated.

29b. Signature and title of certifier: Jagdish Shesadri MD

29c. License number: D 53411

29d. Date signed (Month, Dey, Year): February 10th 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Jagdish Shesadri, Laurel REgional Hosp., 7300 Van Dusen Rd., Laurel,MD. 20707

State Registrar

31. Date filed (Month, Dey, Year): FEB 13 2001

32. Registrar's Signature: Gerdine G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04071

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Paul Perkey

2. Data of Death: Month February Day 7 Yaar 2001

3. Tima of Death: 10:40PM

4a Facility Nama (If not institution, giva street and number): Stella Maris Hospice

4b. City, Town, or Location of Death: Timonium

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 234-20-4741

6. Sax: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Yaar): Dec. 13, 1922

9. Birthplace (Stata or Foraign Country): West Virgina

Usual Rasidance of Decedant

10a. Stata: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1 [ ] Yas 2 [X] No

10e. Street and Number: 100 Bladen Road

10f. Zip Code: 21221

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1 [ ] Navar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1 [X] Yas 2 [ ] No If Yas, Giva Yaar or Datas: 1943-1945

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:

14. Race - Amarican Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highast grada complatad): Elamantary/Secondary (0-12): 8 | Collega (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): Pipe Fitter

16b. Kind of Businass/Industry: Ship Building/Dry Dock

17. Fathar's Name (First, Middla, Last): Walter Paul Perkey

18. Mothar's Nama (First, Middla, Maidan Surnama): Marjorie Williams

19a. Informant's Name/Ralationship (Type, Print): Vennia Perkey (wife)

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 100 Bladen Road, Essex, Maryland 21221

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar (Specify)

20b. Place of Disposition (Nama of cematary, cramatory or othar place): Holly Hill Mem Gardens

Date: Feb. 12 2001

20c. Location - City or Town, Stata: Baltimore, Maryland

21. Signatura of Funeral Service Licensee: Anna E Bruzdzinski

22. Nama and Addrass of Facility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221

Physician /Medical Examiner

23a. Part1. Entar the disaasa, or complications that ceused tha daath. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or haart teilure. List only one ceusa on each line.

Approximata Interval Between Onsat and Death

Immediata Causa (Final disaasa or condition resulting in death)

a. Mesothelioma of Right Chest

Due to (or es a consequence ot):

Sequentially list conditions, if any, laading to immadiata ceuse. Entar Undarlying Cause (Disease or injury that initiated evants rasulting in death) Last

b.

Dua to (or as a consequance of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy parformad? 1 [X] Yas 2 [ ] No

24b. Were autopsy findings available prior to compiation of causa of death? 1 [X] Yas 2 [ ] No

25. Was cesa refarrad to medical examinar? 1 [ ] Yas 2 [X] No

26. Place of Deeth (Check only one): Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatiant 3 [ ] DOA Other: 4 [ ] Nursing Homa 5 [ ] Rasidance 6 [X] Othar (Specify) Hospice

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Panding invastigation 6 [ ] Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurred

28e. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rurel Routa Number, City or Town, Stata)

29a. Certifiar (Check only one) 1 [X] **Certifying Physician**: To tha best of my knowledga, deeth occurred at tha tima, data and place, and dua to tha ceusa(s) and manner as stated. 2 [ ] **Medical Examiner**: On tha basis of axamination and/or invastigetion, in my opinion, daath occurred at tha time, data and place, and dua to tha causa(s) and manner stated.

29b. Signatura and titla of certifier

29c. Licanse number: D43725

29d. Data signad (Month, Day, Yaar): February 10, 2001

30. Nama and addrass of person who completed ceuse of death (Item 23a) (Type, Print): Dr. TariQ Mahmood 2300 Dulaney Valley Road, Timonium, Maryland 21093

State Registrar

31. Data filed (Month, Day, Yaar): FEB 13 2001

32. Registrar's Signatura: G. Koontz

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04072

Plewacki, Theresa

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Theresa Catherine Plewacki

2. Date of Death: Month February Day 11 Year 2001

3. Time of Death: 6:40AM

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215 01 3857

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 6, 1919

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2553 Barrison Point Rd.

10f. Zip Code: 21221

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John Fryza

18. Mother's Name (First, Middle, Maiden Surname): Mary Cebulski

19a. Informent's Neme/Reletionship (Type, Print): Joseph M. Plewacki (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 62 Admiral Blvd. Baltimore, Md. 21222

20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem. Gardens Date: 2/13/01

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funerel Service Licensee: John W. Burkowske MO1091

22. Name and Address of Facility: Bruzdzinski Funeral Home P.A. 1407 OLd Eastern Avenue Essex, Md. 21221

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such es cerdiac or respirefory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in death)

a. Pneumonia — 1week

Due to (or as a consequence of):

b. Wound Dehiscence — 2weeks

Sequentially list conditions, if any, leading to immediete ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last

Due to (or as a consequenca of):

c. Iliopsoas Abcess — 2weeks

Due to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medicel examiner? 1☐ Yes 2☒ No

26. Piece of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funerel director, page 2 should be detached for use es the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(s) end manner stated.

29b. Signature and title of certifier

29c. License number: 198259

29d. Date signed (Month, Day, Year): 2/11/01

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print): William Matsoin MD 9000 Franklin Square Drive Baltimore, Maryland 21237

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04073

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John E. Romig
2. Date of Death (Month, Day, Year): February 9, 2001
3. Time of Death: 4:00 PM
4a. Facility Name (If not institution, give street and number): 110 Victoria Road
4b. City, Town, or Location of Death: Middle River
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-34-5121
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 64 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 2, 1936
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Middle River
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 110 Victoria Road
10f. Zip Code: 21220
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Tool Grinder
16b. Kind of Business/Industry: Container & Machine Co.

17. Father's Name (First, Middle, Last): Wilson Romig
18. Mother's Name (First, Middle, Maiden Surname): Hannah Faber

19a. Informant's Name/Relationship (Type, Print): Brenda Raley (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 41 Bellanca Court, Middle River, Maryland 21220

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holly Hill Mem. Gardens
Date: Feb. 13, 2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Richard Bruzdzinski
22. Name and Address of Facility: Bruzdzinski Funeral Home P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. AS CVD	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. General arteriosclerosis	10 yrs
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Louis Semenoff M.D.
29c. License number: D0010032
29d. Date signed (Month, Day, Year): 2/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LOUIS SEMENOFF 2100 OREMS RD BALTIMORE MD 21220

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001
32. Registrar's Signature: Geneva B. Hooks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04074

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALBERT RITONDALE
2. Data of Death (Month Day Year): FEBRUARY 10, 2001
3. Time of Death: 20:48
4a Facility Name (If not institution, give street and number): Calvert Memorial Hospital
4b. City, Town, or Location of Death: Prince Frederick
4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 130-18-4136
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 73 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): NOV 11, 1927
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Calvert
10c. City, Town or Location: Dunkirk
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4101 Shoreside Place
10f. Zip Code: 20754
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1944-1950
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Staff Accountant
16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Albert Ritondale
18. Mother's Name (First, Middle, Maiden Surname): Rose Albero

19a. Informant's Name/Relationship (Type, Print): Evelyn Ritondale/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4101 Shoreside Place Dunkirk, MD 20754

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.
Date: 2-12-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas Gregor
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CEREBROVASCULAR ACCIDENT — 6 DAYS

Due to (or as a consequence of):
b. HYPERCOAGULABLE STATE — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. LUPUS ANTICOAGULANT

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
PERIPHERAL VASCULAR DISEASE
CORONARY ARTERY DISEASE
DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one)
Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: John Weigel
29c. License number: D26358
29d. Data signed (Month, Day, Year): Feb. 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JOHN WEIGEL, MD 110 HOSPITAL RD. PRINCE FREDERICK, MD. 20678

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001
32. Registrar's Signature: Jenna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04075

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELIZABETH G. ROGERS

2. Date of Death Month: FEB. Day: 09 Year: 2001

3. Time of Death: 9:10am

4e. Facility Name (If not institution, give street and number): KESWICK MULTI CARE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-20-7357

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 06/26/1918

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 700 WEST 40TH ST.

10f. Zip Code: 21211

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE

16b. Kind of Business/Industry: HOMEMAKER

17. Father's Name (First, Middle, Last): HARRY T. GIDDINGS

18. Mother's Name (First, Middle, Maiden Surname): HELEN ASHBY

19a. Informant's Name/Relationship (Type, Print): ROBERT L. ROGERS(SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 222 RIDGEWOOD RD. BALTO.,MD. 21210.

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): UNION CEM. Date: 02/17/2001

20c. Location - City or Town, State: LEESBURG,VA.

21. Signature of Funeral Service Licensee: William C. Davis III

22. Name and Address of Facility: HENRY W. JENKINS & SONS CO. 6500 YORK RD. BALTO.,MD. 21212.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. RESPIRATORY FAILURE

Due to (or as a consequence of):
b. CHRONIC OBSTRUCTIVE LUNG DISEASE — 20 YRS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. ASTHMA — 20 YRS

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

SEVERE DEGENERATIVE JOINT DISEASE

OSTEOPOROSIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D12395

29d. Date signed (Month, Day, Year): 02/09/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHARLES DeJONGH III, MD KESWICK 700 W. 40th St. BALTIMORE, MD 21211

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001

32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04076

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Baby B Rothering
2. Date of Death Month/Day/Year: 2/5/01
3. Time of Death: 13:15 pm
4a. Facility Name (If not institution, give street and number): GBMC
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 111-11-1111
6. Sex: 1☑ M 2☐ F
7. Age (In yrs. last birthday) Yrs.: If Under 1 Year Months / Days; If Under 24 Hrs. Hours / Min.: 11
8. Date of Birth (Month, Day, Year): 2/5/01
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Reisterstown
10d. Inside City Limits: 1☐ Yes 2☑ No
10e. Street end Number: 237 Pidco Road
10f. Zip Code: 21136
10g. Citizen of What Country?: USA

11. Marital Status: 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): N/A College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): N/A
16b. Kind of Business/Industry:

17. Father's Name (First, Middle, Last): David Rothering
18. Mother's Name (First, Middle, Maiden Surname): Kelly Brant

19a. Informant's Name/Relationship (Type, Print): NIKKI CHILCOAT (STAFF)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): GBMC, 6701 N. CHARLES STREET, TOWSON, MD. 21204

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): GREEN MOUNT CREMATORY
Date: 2-8
20c. Location - City or Town, State: BALTIMORE, MD., 21202

21. Signature of Funeral Service Licensee: ▶ R. D. Rutt
22. Name and Address of Facility: HENRY W. JENKINS AND SONS COMPANY 6500 YORK ROAD, BALTIMORE, MD., 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Cardiac arrest	
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last b.	Prematurity	
Due to (or as a consequence of):		
c.	Premature labor + P.R.O.M.	~ 10 wks
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one) Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: ▶ MD
29c. License number: 0022188
29d. Date signed (Month, Day, Year): 2/6/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kamal Hamod, MD Johns Hopkins Greenspring 10753 Falls Road Lutherville, MD 21093

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item 23a Ptl,per Dr. 02/13/01dhb,G792

Certificate of Death

Reg. No. 2001 04077

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Beryl Robinson
2. Date of Death (Month, Day, Year): February 3, 2001
3. Time of Death: 12:15 pm
4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 579-86-5459
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 31, 1919
9. Birthplace (State or Foreign Country): WEST Indies

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 401 Selby Ct.
10f. Zip Code: 21212
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SEAMSTRESS/DESIGNER
16b. Kind of Business/Industry: Self-Employed

17. Father's Name (First, Middle, Last): Thomas John
18. Mother's Name (First, Middle, Malden Surname): ANN JEROME

19a. Informant's Name/Relationship (Type, Print): DR. T. JOAN ROBINSON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 401 Selby Ct. BALTIMORE, Md, 21212

20a. Method of Disposition: 1☑ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARbutus Mem. Pk | Dete: 2/10/2001
20c. Location - City or Town, State: ARbutus, Md

21. Signature of Funeral Service Licensee: Elena Adams Jones
22. Name and Address of Facility: MARSHALL W. JONES, JR. F.H.! P.A. 4101 Edmondson Ave. Balto. Md 21229

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on e ch line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Acute RENAL FAILURE

Due to (or as a consequence of):
Acute Tubular Nerosis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.

Due to (or as a consequence of):
Hypertension

c.

Due to (or as e consequence of):

d.

Part II. Other significant conditiona contributing to death but not resulting in the underlying cause given in Part I.: CARDIOMYOPATHY

23b. Did tobacco usa contribute to the causa of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end manner es statad. 2☐ **Medical Examfnar**: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier:
29c. License number: 019307
29d. Date signed (Month, Day, Year): February, 6 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HERBERT FRIEDMAN Good Samaritan Hospital, 5601 Loch Raven Boulevard Baltimore, Maryland 21239

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001
32. Registrar's Signature: D. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM #14 per fh G793 030501 SS

Certificate of Death

Reg. No. 2001 04078

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jean Schneck

2. Data of Death: Month 2 Day 11 Year 2001

3. Time of Death: 10:07 AM

4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Ctn.

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 196-48-4965

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 42 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): 12-03-58

9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: Apt.#128 5505 Hopkins Bayview Circle

10f. Zip Code: 21224

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Caucasian ~~Black~~

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th yrs. College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Keen Truck Leasing

17. Father's Name (First, Middle, Last): Norman L. Harman

18. Mother's Name (First, Middle, Maiden Surname): Ruby M. Hower

19a. Informant's Name/Relationship (Type, Print): Donna Buse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt #2 Box #3261 Grantville, PA. 17028

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bethel Cemetery

Date: 02-15-01

20c. Location - City or Town, State: Swatara Township, PA

21. Signature of Funeral Service Licensee: Bernard D Johnson

22. Name and Address of Facility: Baltimore, Maryland 21202 WM. C. March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Primary Oxalosis — 2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

End Stage Renal Disease

Respiratory Failure

Cardiac Amyloidosis

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jerry Walston

29c. License number: D38849

29d. Date signed (Month, Day, Year): 2/11/01 2PM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jerry Walston JHGC 5505 Bayview Circle Balto, MD 21224

State Registrar

31. Data filed (Month, Day, Year): FEB 13 2001

32. Registrar's Signature: Penny D. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended item #8 per FHG792 2/13/2001 EW

Certificate of Death

Reg. No. 2001 04079

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Phyllis Simpson

2. Date of Death (Month, Day, Year): February 07, 2001

3. Time of Death: 19:35

4a. Facility Name (If not institution, give street and number): Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-82-1463

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 38 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): ~~April 6, 1962~~ 9-6-62

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4801 Lorelly Ct.

10f. Zip Code: 21206

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): James Simpson

18. Mother's Name (First, Middle, Maiden Surname): Shirley Hunt

19a. Informant's Name/Relationship (Type, Print): Shirley Simpson/mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4801 Lorelly Ct., Baltimore, MD 21206

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory, Inc.

Date: 2/10/01

20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: [signature] M00980

22. Name and Address of Facility: CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures Dr., Towson, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Respiratory failure	1day
Due to (or as a consequence of): b.	Pneumonia	1week
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	aids	unknown
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Asthma

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D45897

29d. Date signed (Month, Day, Year): 2/9/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): YUKARI C. MANABE, 600 NORTH WOLFE STREET, BALTIMORE, MD 21287

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001

32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 04080

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Elsie E. Smith

2. Date of Death — Month: JANUARY Day: 29 Year: 2001

3. Time of Death: 13:04

4a. Facility Name *(If not institution, give street end number)*: FRANKLIN SQUARE HOSPITAL CENTER

4b. City, Town, or Location of Death: ROSEDALE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 215-10-9384

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 8/6/1918

9. Birthplace *(State or Foreign Country)*: Kingsville, Md

Usual Residence of Decedent

10a. State: Md

10b. County: Baltimore

10c. City, Town or Location: Fullerton

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 3 Hallbrook Court

10f. Zip Code: 21236

10g. Citizen of Whet Country?: USA

11. Meritel Stetus: 1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - Americen Indien, Bleck, White, etc. *Specify:* white

15. Decedent's Eduction *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 7 Years — College (1-4or 5+): N/A

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Receiving Clerk

16b. Kind of Business/Industry: Retail

17. Father's Neme *(First, Middle, Last)*: John Stricklin

18. Mother's Name *(First, Middle, Maiden Surname)*: Grace Kerr

19a. Informant's Neme/Reletionship *(Type, Print)*: Arthur Smith (son)

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 1137 Pine Rd. Carlisle, PA 17013

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other place)*: Fork Methodist Church Cemetery — Dete: 2/3/2001

20c. Location - City or Town, Stete: Fork, MD

21. Signature of Funeral Service Licensee: E. F. Lassahn

22. Name end Address of Fecility: E.F.Lassahn Funeral Home 11750 Belair Rd. Kingsville, MD 21087

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximete Intervel Between Onset end Death

Immediate Ceuse (Finel disease or condition resulting in deeth)
e. Myocardial Infarct

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediete ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest
b. Ischemic Heart Disease

Due to (or es e consequence of):
c. Hypertension

Due to (or es e consequence of):
d.

Part II. **Other significent conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

Hyperlipidemia
Hypothyroidism
Gastric Adenocarcinoma

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☒ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: Howard H Bond MD

29c. License number: D19793

29d. Date signed *(Month, Day, Year)*: 1/30/01

30. Neme end address of person who completed ceuse of death (Item 23a) (Type, Print): HOWARD BOND, MD. 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 13 2001

32. Registrer's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

R

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04081

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ann Amelia Smith

2. Date of Death (Month, Day, Year): FEBRUARY 9 2001

3. Time of Death: 8:50AM

4a. Facility Name (If not institution, give street and number): ST AGNES HEALTHCARE

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-18-0886

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): FEB 27, 1916

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 14 A Sanford Avenue

10f. Zip Code: 21228

10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk

16b. Kind of Business/Industry: Baltimore County

17. Father's Name (First, Middle, Last): Albert Smith

18. Mother's Name (First, Middle, Maiden Surname): Bertha Eckles

19a. Informant's Name/Relationship (Type, Print): Elsie Griffin/Cousin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 321 School Lane Linthicum, MD 21090

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.

Date: 2-10-01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas Gregor

22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. BRAIN TUMOR

Due to (or as a consequence of):

b. GASTRO INTESTINAL BLEEDING

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Charles Curtis MD

29c. License number: D5001865

29d. Date signed (Month, Day, Year): February 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHARLES CURTIS ST AGNES HOSPITAL BALTIMORE MD

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

ANN SMITH

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001

32. Registrar's Signature: Jenna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

RKD

01-0652-031

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

MARI SYMOW

State of Maryland / Department of Health and Mental Hygiene — Certificate of Death

2001 04082

1- For State Registrar AMENDED ITEMS# 23,27& 28a-f per ME G792 022101 SS

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mari Symon

2. Date of Death (Month, Day, Year): FEBRUARY 6, 2001

3. Time of Death: 2:10P. M

4a. Facility Name (If not institution, give street and number): 4710 BETHESDA AVE

4b. City, Town, or Location of Death: BETHESDA

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 280-54-6309

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 46 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): AUG 13, 1954

9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 4710 Bethesda Avenue Apt #1018

10f. Zip Code: 20814

10g. Citizen of What Country? USA

11. Maritat Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 5 +

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Producer/Writer

16b. Kind of Business/Industry: Broadcasting

17. Father's Name (First, Middle, Last): Frank Koenig

18. Mother's Name (First, Middle, Maiden Surname): Dorothy UNK.

19a. Informant's Name/Relationship (Type, Print): Michele Chavalia/Executrix

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1713 Willow Park Court Powell, OH 43065

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.

Date: 2-10-01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik

22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. DRUG INTOXICATION

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as e consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☒Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery: Month Day Year

Part ff. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) SCENE

27. Manner of Death: 1☐Natural 2☐Accident 3☒Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year) found: 2/6/01

28b. Time of Injury found: 2:00 PM

28c. Injury at Work? 1☐Yes 2☒No

28d. Describe how injury occurred: subject ingested drugs

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): found at home

28f. Location (Street and Number or Rural Route Number, City or Town, State): 4710 Bethesda Ave., Bethesda, MD

29a. Certifier (Check only one)

1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated.

2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: J. Pestaner M.D.

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): FEBRUARY 7, 2001

30. Name and Address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001

32. Registrar's Signature: Geneva B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-656-510
CYNTHIA SCHIANO
JVW

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEMS# 23a & 27 per ME G792 021401 SS

Certificate of Death

Reg. No. 2001 04083

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Cynthia Schiano
2. Date of Death Month Dey Yaar: FEBRUARY 07, 2001
3. Time of Death: 03:30 A.M.
4a. Facility Name (If not institution, give street and number): 4212 HARFORD ROAD
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 508-72-2508
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthdey): 47 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): JUNE 5, 1953
9. Birthplece (State or Foreign Country): Maryland

Usuel Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4212 Harford Road
10f. Zip Code: 21214
10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐ Never Merried 2☐ Merried 3☐ Widowed 4☒ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Americen Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 9; College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales
16b. Kind of Business/Industry: Retail

17. Fether's Neme (First, Middle, Last): Albert Schiano
18. Mother's Nama (First, Middle, Maiden Surname): Joan Wesko

19a. Informent's Neme/Reletionship (Type, Print): Joan A. Schiano/Mother
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 3220 Woodring Avenue Baltimore, MD 21234

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Plece of Disposition (Neme of cemetery, cremetory or other place): Metro Crematory Inc.
Dete: 2/9/01
20c. Location - City or Town, Stete: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failura. List only one ceuse on eech line. (Approximete Interval Between Onset end Death)

Immediate Cause (Finel diseese or condition resulting in deeth): a. CHRONIC NARCOTISM
Due to (or as e consequance of):
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last
b.
Due to (or es e consequenca of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uae contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes en eutopsy performed? 1☑ Yes 2☐ No
24b. Were eutopsy findings eveilable prior to completion of cause of death? 1☑ Yes 2☐ No

25. Wes case referred to medicat exeminer? 1☒ Yes 2☐ No
26. Place of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Othar (Specify) SCENE

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigetion 6☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☒ **Medical Examiner:** On the besis of examinetion end/or investigation, in my opinion, death occurred at the time, date end pleca, end due to the cause(s) end menner steted.
29b. Signature end title of certifier: Joseph Pestaner, M.D.
29c. Licansa number: O.C.M.E.
29d. Date signed (Month, Dey, Yeer): FEBRUARY 07, 2001
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Dey, Yeer): FEB 13 2001
32. Registrar's Signature: Geneva B. Sparks

Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04084

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lois Franklin Sanders
2. Date of Death (Month, Day, Year): February 11, 2001
3. Time of Death: 10:30 PM
4a. Facility Name (If not institution, give street and number): 4127 Bedford Rd
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 461-46-8007
6. Sex: 1☐M 2☐F XX
7. Age (In yrs. last birthday): 65 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 22, 1935
9. Birthplace (State or Foreign Country): TX

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Randallstown
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 4127 Bedford Road
10f. Zip Code: 21133
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Yeer or Detes: Korean War
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Reca - American Indien, Black, White, etc. Specify: White

15. Decedent's Eduestion (Specify only highest grade completed): Elementery/Secondery (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Machinist
16b. Kind of Business/Industry: Manufacturing

17. Fether's Neme (First, Middle, Last): Lois Franklin Sanders, Sr.
18. Mother's Name (First, Middle, Maiden Surneme): Anne Gailey

19e. Informent's Neme/Relationship (Type, Print): Theresa M. Sanders Wife
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4127 Bedford Road, Randallstown, MD 21133

20a. Method of Disposition: 1☐Burial 2☒Cremetion 3☐Removel from State 4☐Donetion 5☐Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): Carroll Cremations
Dete: 2/12/01
20c. Location - City or Town, State: Hampstead, MD

21. Signature of Funeral Service Licensee: Edward B Eline
22. Name end Address of Feeility: Eline Funeral Home 11824 Reisterstown Rd. Reisterstown, Md 21136

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heart feilure. List only one ceuse on eech line. (Approximete Intervel Between Onset end Death)

Immediate Ceuse (Finel disease or condition resulting in death): e. Ischemic Heart Disease

Due to (or as e consequence of):

Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I. Pneumonia right cerebrally Accident; Peripheral Vascular Disease

23b. Did tobacco uee contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Wes en autopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1☐Yes 2☒No

25. Wes cese referred to medicel exeminer? 1☐Yes 2☒No

26. Piece of Deeth (Check only one): Hospitel: 1☐Inpetient 2☐ER/Outpetient 3☐DOA; Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Menner of Deeth: 1☐Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28e. Dete of Injury (Month, Day Yeer)
28b. Time of Injury: M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. 2☐Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Edward Sleman
29c. License numbar: D19171
29d. Date signed (Month, Day, Year): Febuary 12th, 2001

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print): Edward Sleman 4000 Old Court Road Pikesville maryland 21208

State Registrar

31. Dete filed (Month, Day, Year): FEB 13 2001
32. Registrer's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04085

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN SWOPE
2. Date of Death (Month, Day, Year): FEBRUARY 09 2001
3. Time of Death: 12:11 pm
4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER.
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-05-4450
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 87 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 14, 1913
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 3911 Second Street
10f. Zip Code: 21225
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: 01/42 09/45
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Meat Packer
16b. Kind of Business/Industry: Eskay

17. Father's Name (First, Middle, Last): Charles Swope
18. Mother's Name (First, Middle, Maiden Surname): Nellie Frank

19a. Informant's Name/Relationship (Type, Print): Sandy Seabrease (Niece)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3911 Second Street Baltimore, MD 21225

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Mem. Park
Date: 2/13/01
20c. Location - City or Town, State: Glen Burnie, MD

21. Signature of Funeral Service Licensee: Shannon Liggett
22. Name and Address of Facility: Gonce Funeral Home, P.A. 4001 Ritchie Highway Baltimore, MD 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. VENTRICULAR TACHYCARDIA	30 minutes
Due to (or as a consequence of):	b. ISCHEMIC HEART DISEASE	1 day.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: RENAL FAILURE, DIABETES MELLITUS, HYPERTENSION, CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury: M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: P13477
29d. Date signed (Month, Day, Year): FEBRUARY 09, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MYA S. THEIN. 3001, SOUTH HANOVER STREET. BALTIMORE, MD 21225.

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001
32. Registrar's Signature: Sandra G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

CPS
01-0670-510
RAYMOND TYLER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEMS# 23a,b,pt II,& 27 per attached affs

Certificate of Death

Reg. No. 2001 04086

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Raymond Tyler			February 7, 2001	10:19 AM
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
Mercy Hospital	Baltimore		NA	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-40-1825	1☐M 2☐F	61 Yrs.			10-02-39	MD

Usuet Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
919 North Durham Street	21205	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
GED	NA	Laborer	various trades

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Tyler	Florence Wright

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21205
Doris Stern	919 N. Durham Street Baltimore, Maryland

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
☒Buriel 2☐Cremation 3☐Removel from State 4☐Donation 5☐Other (Specify)	Voshell Mem.Gardens	02-13-01	Dundalk, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Gladys Ware	Baltimore,Maryland 21202 WM.C.March FH 1101 E. North Avenue

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CARDIAC ARRHYTHMIA	
	Due to (or as e consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☒Yes 2☐No

25. Was case raferred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Dennis J Chutes	OCME	February 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis Chutes 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 13 2001	Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04087

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WALTER TERRELL
2. Deta of Death Month FEBRUARY Dey 6, Year 2001
3. Time of Death: 10:05 AM
4e Facility Neme (If not institution, give street end number): LAUREL REGIONAL HOSPITAL
4b. City, Town, or Location of Death: LAUREL
4c. County of Deeth: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 218-12-4733
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthdey): 76 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Year): JAN.31,1925
9. Birthplace (Stete or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 X Yes 2 ☐ No
10e. Street end Number: 5220 YORK ROAD
10f. Zip Code: 21212
10g. Citizen of Whet Country?: U.S.A.
11. Meritel Stetus: 1 ☐ Never Merried 2 ☐ Merried 3 X Widowed 4 ☐ Divorced
12. Was Decedent Evar In U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Yeer or Detas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1 ☐ Yes 2 X No Specify:
14. Race - Americen Indian, Bleck, White, etc. Specify: BLACK
15. Decedent's Educetion (Specify only highest grade completed): Elementery/Secondery (0-12): 12 / Collega (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): MASTER ELECTRICIAN
16b. Kind of Business/Industry: WALL ELECTRIC
17. Fathar's Neme (First, Middle, Last): WALTER TERRELL, SR.
18. Mother's Name (First, Middle, Maiden Sumame): GRACE SIMMS
19e. Informant's Name/Reletionship (Type, Print): PHYLLIS TOWNES / DAUGHTER
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1303 HOBGOOD ROAD - SCOTTLENDNECK, NC 27874
20e. Method of Disposition: 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or othar piece): MD VETERANS CEMETERY
Data: 2/12/01
20c. Location - City or Town, State: OWINGS MILLS, MD
21. Signature of Funeral Service Licensee: Jay Fol
22. Nama and Addrass of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximele Intervel Between Onset end Death

Immediete Ceuse (Final disease or condition resulting in deeth)
e. Pneumonia — Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in death) Lest
b. — Due to (or es a consequence of):
c. — Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
cerebral vascular ischemia

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☐ No 3 ☐ Probably X Unknown

24a. Wes en autopsy performed? 1 ☐ Yes 2 X No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1 ☐ Yes 2 X No

25. Wes cese referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Deeth (Check only one): Hospitel: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residance 6 ☐ Other (Specify)

27. Menner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined

28e. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29e. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) and menner es steted. 2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and menner steted.

29b. Signature and title of certifier: M.D.
29c. License number: D54853
29d. Date signed (Month, Day, Year): 2/7/01

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print): 8317 Cherry Ln, Laurel MD 20707 (DR. LEE)

State Registrar

31. Dete filed (Month, Dey, Year): FEB 12 2001
32. Registrer's Signetura: Barbara B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#23a ptII,28a-f perPHYG792 2/13/2001 EW **Certificate of Death**

Reg. No. 2001 04088

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret M Wajbel
2. Date of Death (Month, Day, Year): February 1, 2001
3. Time of Death: 9:00 Am
4a. Facility Name (If not institution, give street and number): Saint Joseph Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 207-14-8597
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 29, 1927
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6218 Danville Avenue
10f. Zip Code: 21224
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 Years | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Charles Mannel
18. Mother's Name (First, Middle, Maiden Surname): Jennie Ellis

19a. Informant's Name/Relationship (Type, Print): Sharon Cooper (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6 Stone Row Court Cockeysville, MD 21030

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem. Gdns. Date: 2/5/2001
20c. Location - City or Town, State: Timonium, MD

21. Signature of Funeral Service Licensee: Stephanie Massey
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardio-Pulmonary Failure
Due to (or as e consequence of):
b. Arteriosclerotic Cardio Renal Vascular Disease
Due to (or es a consequence of):
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

~~Infection at Site of Hip Replacement post surgery Nov 2000~~

Fractured Hip

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ ~~Unknown~~

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): 11/5/2000
28b. Time of Injury: 2:30 P M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: FELL OFF CHAIR
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): At Home
28f. Location (Street and Number or Rural Route Number, City or Town, State): 6218 Danville AVE

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end menner es steted. 2☒ **Medical Examiner:** On the besis of exeminetion end/or Investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Charles F O'Donnell MD
29c. License number: D-09383
29d. Date signed (Month, Day, Year): February 1, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles F O'Donnell MD 111 Hamlet Hill Rd Baltimore Md 21210

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001
32. Registrar's Signature: Penny B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 23a Pt. I per Dr. G792,02/14/01dnb

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04089

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month Day Year	3. Time of Death
Melvin Jerome Welsh	FEBRUARY 5, 2001	4:56 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Saint Joseph Medical Center	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-20-4669	1☒ M 2☐ F	73 Yrs.					February 27,1927	Baltimore, Maryland

Usual Residance of Decedant

10a. State	10b. County	10c. City, Town or Location	10d. Insida City Limits
Maryland	Baltimore Co.	Timonium	1☐ Yas 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
113 Washington Street	21093-2213	United States of America

11. Marital Status	12. Was Decedant Ever in U.S. Armed Forcas?	13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, Whita, atc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yas 2☐ No If Yes, Giva Yaar or Datas: 9/16/46 to 9/5/50	1☐ Yas 2☒ No Specify:	Specify: White

15. Decedant's Education (Specify only highast grada completed)		16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired)	16b. Kind of Business/Industry
Elamantary/Secondery (0-12)	Collega (1-4or 5+)		
11	n/a	Supervisor of Maintenance	Church of the Nativity

17. Fathar's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maidan Sumama)
John Patrick Welsh	Bertha Firtsch

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)
Mrs. Myra Betty(nee Lang)Welsh(Wife)	113 Washington Street Timonium, Maryland 21093-2213

20a. Mathod of Disposition	20b. Place of Disposition (Nama of cematary, cramatory or othar place)	Data	20c. Location - City or Town, State
1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other (Specify)	Meadowridge Memorial Park	02/08/2001	Elkridge, Maryland

21. Signatura of Funeral Service Licensee	22. Nama and Address of Facility
Jeffrey L. Gair, Sr.	Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204-2515

Physician /Medical Examiner

23a. Part I. Entar the disaase, or complications that caused the daath. Do not antar tha moda of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on aach lina.

		Approximata Interval Between Onsat and Death
Immediata Causa (Final diseasa or condition resulting in death)	a. RESPIRATORY FAILURE	
	Due to (or as a consequance of): Adult Respiratory Distress Syndrome	
Sequentially list conditions, if eny, leading to immadiate cause. Entar Underlying Causa (Disaase or Injury that initiated events resulting in death) Lest	b. ~~MULTI ORGAN SYSTEM FAILURE~~	
	Due to (or as a consequance of): Internal Wound Infection	
	c.	
	Dua to (or as a consequance of):	
	d.	

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying ceusa given in Part I.

23b. **Did tobacco use contribute to the causa of death?** 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Ware eutopsy findings eveileble prior to complation of ceusa of daath?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case rafarred to medical examinar?	26. Placa of Death (Check only ona)	
1☐ Yas 2☒ No	Hospitel: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify)

27. Mannar of Death	28a. Dete of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined		M	1☐ Yes 2☐ No	
	28a. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one)
1☒ **Certifying Physician**: To the best of my knowledga, death occurred at the time, dete end piece, end dua to the causa(s) and mannar as stated.
2☐ **Medical Examiner**: On tha basis of examinetion and/or invastigation, in my opinion, deeth occurred at the time, dete end piece, end due to the causa(s) and mannar stated.

29b. Signatura and title of certifier	29c. License number	29d. Data signed (Month, Day, Year)
John W Eppler	D26002	2/5/01

30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print)
JOHN EPPLER, M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signeture
FEB 13 2001	Denise D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Melvin Welsh

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04090

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELIZABETH WHITE

2. Date of Death (Month, Day, Year): February 09 2001

3. Time of Death: 2:32P

4a. Facility Name (If not institution, give street and number): Bon Secours Hospital

4b. City, Town, or Location of Death: Balto. city

4c. County of Death:

Funeral Director

5. Social Security Number: 220-24-9513

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 03 04 14

9. Birthplace (State or Foreign Country): P.A.

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 107 North Hilton Street

10f. Zip Code: 21229

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th grade

College (1-4or 5+): na

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Custodian

16b. Kind of Business/Industry: Balto City Schools

17. Father's Name (First, Middle, Last): Unknown

18. Mother's Name (First, Middle, Maiden Surname): Inez Bolling

19a. Informant's Name/Relationship (Type, Print): Barbara Smith-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5501 Elderon Ave, Baltimore Md 21215

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Druid Ridge Cemetery

Date: 2/14/01

20c. Location - City or Town, State: Pikesville, Md

21. Signature of Funeral Service Licensee: Jerome F. Thompson

22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore, Maryland 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. ACUTE MYOCARDIAL INFARCTION — 4 hrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ARTERIOSCLEROTIC HEART DISEASE — unknown

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENTION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D 23300

29d. Date signed (Month, Day, Year): February 09 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SUDHIR. PATEL BON SECOURS HOSP. 2000 W Balto St. BALTO MD. 21223

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 04091

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
George R. Walter	Feb.	11	2001	3:30 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3001 Bradenbaugh Rd.	White Hall	Harford

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-24-4470	1☐M 2☐F	70 Yrs.			June 20 1930	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Harford	White Hall	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
3001 Bradenbaugh Rd.	21161	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Bleck, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: '50-'55	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11	n/a	Garage Owner	Service Station

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surneme)
James B. Walter	Freida Fuller

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Jean M. Walter/wife	3001 Bradenbaugh Rd., White Hall, MD 21161

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, Stete
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Dulaney Valley Memorial Gardens	2/14/01	Timonium, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Bryan W. Clary	Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or keert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in deeth)	a. Lung Cancer	3 Months
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Wes decedent pregnent in the pest 12 months?	23c. If yes, outcome of pregnancy	23d. Dete of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent et time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Headand Neck Cancer

23e. Did tobecco use contribute to the cause of death?	24a. Was en autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?
1☒Yes 2☐No 3☐Probebly 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Menner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end menner as steted.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
▶ Mark Lamos MD	D32405 3	2-11-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mark Lamos, M.D. 9 Schilling Rd., Suite 1, Hunt Valley, MD 21031

State Registrar

31. Date filed (Month, Day, Yeer)	32. Registrar's Signature
FEB 13 2001	▶ Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND#7 PER F.H. G792 1-14-2001 JAB

Certificate of Death

Reg. No: 2001 04092

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
WILFRED H. WATERS	FEBRUARY 11, 2001	6 pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2033 32nd STREET	BALTIMORE	N / A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-36-7192	X 1 M 2 F	71 Yrs.			OCT. 12, 1929	WASHINGTON DC.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	N / A	BALTIMORE	1 X Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2033 E. 32nd STREET	21218	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 X Married 3 Widowed 4 Divorced	1 X Yes 2 No If Yes, Give Year or Dates: 7/25/51 - 4/24/53	1 Yes 2 X No Specify:	AFRO AMERICAN Specify:

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6		STERLIZING OPERATOR	J.H. HOSPITAL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JAMES WATERS	CARRIE CHISLEY

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JOCELYN READ (DAUGHTER)	7286 MC CLEAN BLVD. BALTO. MD. 21234

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
X 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	GARRISON FOREST VET. CEM.	FEB 16, 2001	BALTO. MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME
1412 E. PRESTON STREET BALTO MD. 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. metastatic prostate Cancer	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 X No	1 Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 X No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 X Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature] MD	P 12408	2/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Robert HADDAD MD, 10 N Greene Street, Baltimore, MD, 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 13 2001	[signature] D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04093

White, Elizabeth P

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELIZABETH P. WHITE
2. Date of Death (Month, Day, Year): February 9 2001
3. Time of Death: 6:55 P.M.
4a. Facility Name (If not institution, give street and number): North Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 407-46-4581
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPT. 21, 1929
9. Birthplace (State or Foreign Country): SCOTLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 304 BROADWAY AVENUE
10f. Zip Code: 21061
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): JOCK DOUGAL
18. Mother's Name (First, Middle, Maiden Surname): MARY WRIGHT

19a. Informant's Name/Relationship (Type, Print): DOUGLAS WHITE (SON)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 304 BROADWAY AVENUE, GLEN BURNIE, MD. 21061

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GLEN HAVEN MEMORIAL PARK
Date: 2/12/2001
20c. Location - City or Town, State: GLEN BURNIE, MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. CARDIAC TAMPONADE
Due to (or as a consequence of):
b. RESPIRATORY FAILURE
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. PANCREATITIS
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D43977
29d. Date signed (Month, Day, Year): February 9 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mark Dillman 301 Hospital Drive Glen Burnie MD 21061

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001
32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04094

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen A. Windham

2. Date of Death: Month February, Day 9, Year 2001

3. Time of Death: 7:00 A.M.

4a. Facility Name (If not institution, give street and number): Heritage Harbour Health & Rehab. Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 213 64 2275

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): August 18, 1910

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Linthicum

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 824 White Avenue

10f. Zip Code: 21090

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Michael Schultz

18. Mother's Name (First, Middle, Maiden Surname): (not available)

19a. Informant's Name/Relationship (Type, Print): Toni Carr / Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 824 White Avenue Linthicum, Maryland 21090

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) Entombment

20b. Place of Disposition (Name of cemetary, crematory or other place): Cedar Hill Cemetery

Date: 2/13/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Donna M Braniewski

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Ischemic cardiomyopathy — Yrs

Due to (or as a consequence of):
b. Chronic Atrial Fibrillation — Yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: N. Tavakoli MD

29c. License number: D41978

29d. Date signed (Month, Day, Year): 2-9-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nader Tavakoli 9801 #212 Greenbelt Rd Lanham MD 20706

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001

32. Registrar's Signature: Donna B Gordon

ORIGINAL

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 04095

NAME KNOWN TO PHYSICIAN: YANCY, PAUL L.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Paul Leroy Yancy, Sr.

2. Dete of Deeth — Month: FEBRUARY Dey: 2, Year: 2001

3. Time of Death: 8:50PM

4e Facility Name *(If not institution, give street and number)*: VA MARYLAND HEALTH CARE SYSTEM

4b. City, Town, or Location of Death: PERRY POINT

4c. County of Death: CECIL

Funeral Director

5. Social Security Number: 118-12-8834

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthdey)*: 79 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Year)*: June 6, 1921

9. Birthplece *(Stete or Foreign Country)*: Virginia

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 3301 Avondale Avenue

10f. Zip Code: 21215

10g. Citizen of Whet Country?: USA

11. Mertel Stetus: 1☐ Never Married 2☒Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Detes: 9/3/43 – 11-4-43

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specity Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒No *Specify:*

14. Race - American Indian, Bleck, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12th grade; College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver

16b. Kind of Business/Industry: kane Transfer Company

17. Father's Neme *(First, Middle, Last)*: Charlie Yancy

18. Mother's Neme *(First, Middle, Maiden Surneme)*: Nora Coleman

19e. Informant's Name/Reletionship *(Type, Print)*: Sally Yancy/ wife

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 3301 Avondale Avenue Baltimore, maryland 21215

20e. Method of Disposition: 1☒Buriel 2☐Cremetion 3☐Removel from Stete 4☐Donetion 5☐Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Garrison Forest Veterans Cemetery

Dete: 2/7/2001

20c. Location - City or Town, State: Owings Mills, Md

21. Signeture of Funeral Service Licensee: Gary Harris

22. Name end Address of Facility: Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, Maryland 21215

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset end Death

Immediete Cause (Final disease or condition resulting in deeth): e. CHRONIC OBSTRUCTIVE PULMONARY DISEASE — UNKNOWN

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in death) Lest

b. Due to (or es e consequence of):

c. Due fo (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but nof resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☒Inpetient 2☐ER/Outpetient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Menner of Deeth: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: M. Shandelya

29c. License number: D52739

29d. Dete signed *(Month, Dey, Year)*: FEBRUARY 2, 2001

30. Nema end address of person who completed cause of deeth (Item 23a) (Type, Print): SURESH SHANDELYA, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND 21902

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: FEB 13 2001

32. Registrer's Signeture: Benita D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

amend item 20c per fh G792 2/13/01 yf

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04096

Kathleen, Yeates.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Data of Death Month	Day	Year	3. Time of Death
KATHLEEN	YEATES	February	11	2001	7:15am.

4a Facility Name (If not institution, give street end number)	4b. City, Town, or Location of Death	4c. County of Death
UNION MEMORIAL HOSPITAL	BALTIMORE	NA

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthdey)	If Under 1 Year Months	If Under 1 Year Deys	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Dey, Year)	9. Birthpleca (Steta or Foreign Country)
245-07-3382	1☐ M 2☒ F	87 Yrs.					FEB 27 1913	N.C.

Usual Residence of Decedent

10a. Stete	10b. County	10c. City, Town or Location	10d. Insida City Limits
MD	NA	BALTIMORE	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
601 WYANOKE AVE. APT. 552	21218	U S A

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, atc.)	14. Race - Americen Indien, Black, White, etc.
1☐ Never Married 2☐ Merried 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondery (0-12)	College (1-4or 5+)		
8th	NA	LABORER	FACTORY

17. Father's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
FRANK DEAL	MAMIE WILLIS

19e. Informant's Name/Relationship (Type, Print)	19b. Meiling Address (Street and Number or Rurel Routa Number, City or Town, Stete, Zip Code)
OLLA WADE - DAUGHTER	911 VANDERWOOD RD, CATONSVILLE, MD 21228

20e. Method of Disposition	20b. Place of Disposition (Neme of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, Stete
1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)	DEAL CEMETERY	2-16-01	~~AUROUA~~, N.C. Aurora

21. Signature of Funeral Service Licensee ▶ Glynn B. Keto

22. Name and Address of Facility: MARCH FUNERAL HOME WEST, INC. BALTIMORE, MD 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

		Approximete Interval Between Onset and Death
Immediete Ceuse (Final diseese or condition resulting in death)	e. Sepsis	1½ weeks
	Due to (or es e consequence of):	
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last	b.	
	Due to (or as e consequence of):	
	c.	
	Dua to (or es e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were eutopsy findings available prior to complation of cause of deeth?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Wes cese referred to medicel examiner?	26. Piece of Deeth (Check only one)	
1☐ Yes 2☒ No	Hospitel: 1☑ Inpatient 2☐ ER/Outpetient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Othar (Specify)

27. Menner of Death	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Neturel 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or Investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(s) and manner stated.

29b. Signatura and titla of certifiar	29c. Licansa number	29d. Date signed (Month, Dey, Year)
▶ Onaje A.	AT243946.	February 11, 2001.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Onaje Greene, Union Memorial Hospital, Baltimore Maryland.

State Registrar

31. Dete filed (Month, Dey, Year)	32. Registrar's Signeture
FEB 13 2001	▶ D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04097

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DOROTHY V. YOUNG

2. Date of Death Month: February Day: 7 Year: 2001

3. Time of Death: 15:15 pm

4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death:

Funeral Director

5. Social Security Number: 212-22-9163

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 94 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 27, 1906

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD.

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8720 Ridge Road

10f. Zip Code: 21043

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Buyer Assistant

16b. Kind of Business/Industry: Department Stores

17. Father's Name (First, Middle, Last): Unknown -Story

18. Mother's Name (First, Middle, Maiden Surname): Genevieve -Unknown

19a. Informant's Name/Relationship (Type, Print): Ralph S. Young- Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 136 Mike Court, Elkton, Maryland 21921

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore/WashingtonCrem

Date: 02/13/01

20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: Brian Dabrowski

22. Name and Address of Facility: Witzke Funeral Home, Inc. 1630 Edmondson Avenue, Catonsville, Maryland21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ASPIRATION PNEUMONIA — 1 DAY

Due to (or as a consequence of):

b. SUBARACHNOID HEMORRHAGE — 3 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD, PHD, RESIDENT

29c. License number: RBS-000

29d. Date signed (Month, Day, Year): FEBRUARY 7, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): SAURABH R. SINHA, JOHNS HOPKINS HOSPITAL, BALTIMORE, MD

State Registrar

31. Date filed (Month, Day, Year): FEB 13 2001

32. Registrar's Signature: Barbara B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04098

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eugene Phillips Andes

2. Date of Death Month Dey Year: January 26, 2001

3. Time of Death: 2335

4e Facility Neme (If not institution, give street end number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Deeth: Washington

Funeral Director

5. Social Security Number: 167-09-8791

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthdey): 91 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Year): Jan. 20, 1910

9. Birthplace (Stete or Foreign Country): West Virginia

Usuel Residence of Decedent

10a. Stete: Md.

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 17903 Oak Ridge Drive

10f. Zip Code: 21740

10g. Citizen of Whet Country?: USA

11. Merifel Stetus: 1 [ ] Never Merried 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Wes Decedenf Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1942 - 1946

13. Wes Decedenf of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Educefion (Specify only highest grade completed): Elementery/Secondary (0-12): | College (1-4or 5+): 5

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Petroleum Engineer

16b. Kind of Business/Industry: Steel Company

17. Fether's Neme (First, Middle, Last): William Franklin Andes

18. Mother's Neme (First, Middle, Maiden Surname): Sophis Inez Knippenberg

19a. Informent's Neme/Reletionship (Type, Print): Shirley Caniford - Niece

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): P. O. Box 137 - Harpers Ferry, WV 25425

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Harper Cemetery

Dete: 1/31/2001

20c. Location - City or Town, Stete: Harpers Ferry, WV

21. Signature of Funerel Service Licensee: Robt L. Spencer

22. Neme end Address of Fecility: Eackles-Spencer Funeral Home Harpers Ferry, WV 25425

Physician /Medical Examiner

23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert teilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Finel disease or condition resulting in deeth)

e. Congestive heart failure

Due to (or as e consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest

b. Coronary Artery Disease

Due to (or as e consequenca of):

c. Atherosclerosis

Due fo (or es a consequenca of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Obstructive Sleep Apnea

Renal Insufficiency

23b. Did tobacco uae contribute to the cauae of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24e. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [/] No

26. Place of Death (Check only one): Hospital: 1 [/] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [/] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigefion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1 [/] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred ef the time, date end placa, end due to the ceuse(s) end menner steted.

29b. Signature end fitle of certifier: Frederick Klaus III MD

29c. License number: D23623

29d. Date signed (Month, Dey, Year): January 27, 2001

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Frederick Klaus III MD 11110 Medical Campus Rd, Hagerstown Md

State Registrar

31. Dete filed (Month, Dey, Year): JAN 29 2001

32. Registrer's Signefure: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funerel director, page 2 should be detached for use as the burial-transit

Andes, Eugene

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04099

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JAMES RATTRAY BENFORD

2. Date of Death Month Day Year: January 27 2001

3. Time of Death: 11:45 PM

4a. Facility Name *(If not institution, give street and number)*: Genesis ElderCare - The Pines

4b. City, Town, or Location of Death: Easton

4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 128-05-7234

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 12/9/1913

9. Birthplace *(State or Foreign Country)*: NEW YORK

Usual Residence of Decedent

10a. State: MD

10b. County: TALBOT

10c. City, Town or Location: EASTON

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10a. Street and Number: 29663 TALLULAH LANE

10f. Zip Code: 21601

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: OPTICAL ENGINEER

16b. Kind of Business/Industry: VISUAL INSTRUMENTS

17. Father's Name *(First, Middle, Last)*: FRANK G. BENFORD

18. Mother's Name *(First, Middle, Maiden Surname)*: GEORGIA RATTRAY

19a. Informant's Name/Relationship *(Type, Print)*: JAY R. BENFORD/SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 29663 TALLULAH LANE, EASTON, MD 21601

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CHESAPEAKE CREMATION CTR. Date: 1/29/01

20c. Location - City or Town, State: STEVENSVILLE, MD

21. Signature of Funeral Service Licensee: [signature] CFSP

22. Name and Address of Facility: FELLOWS, HELFENBEIN, & NEWNAM FUNERAL HOME, 200 SOUTH HARRISON STREET, EASTON, MD 21601

To Be Completed by Funeral Director

James Benford
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Inanition. — 2 weeks

Due to (or as a consequence of):
b. Dementia. — 3 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Atherosclerotic Cardiovascular Dz. — 5 yr

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: H42587

29d. Date signed *(Month, Day, Year)*: 01/29/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RUSSELL SCHILLING MD 555 CYNWOOD DRIVE EASTON, MD 21601

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

SBB

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 30 2001

32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04100

George Byris

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George E. Byris, Jr.
2. Date of Death (Month, Day, Year): January 31 2001
3. Time of Death: 1300
4a. Facility Name (If not institution, give street and number): The Memorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 218-30-2134
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 64 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 26, 1936
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Caroline
10c. City, Town or Location: Ridgely
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 11990 Central Ave.
10f. Zip Code: 21660
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver
16b. Kind of Business/Industry: Perdue Farms

17. Father's Name (First, Middle, Last): George E. Byris, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Carrie Tiller

19a. Informant's Name/Relationship (Type, Print): Norma Lee Byris, wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 241, Ridgely, Maryland 21660

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cokers Cemetery
Date: 02/05/01
20c. Location - City or Town, State: Greensboro, Md.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Bennie Smith Funeral Home, P.O. Box 1687, Easton, Maryland 21601

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Respiratory failure	12 hours
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	Hepatopulmonary syndrome	2 days
Due to (or as a consequence of):		
c.	Hepatic failure	3 days
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hepatorenal syndrome

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Hara Laura Jin
29c. License number: D0055484
29d. Date signed (Month, Day, Year): 1-31-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. H. Laura Jin, 219 S. Washington Street, Easton, Maryland 21601

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signature: [signature] G. Sparks

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04101

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Jesse Lee Baugher

2. Date of Death Month / Day / Year: January 25, 2001

3. Time of Death: 5:28 P.M.

4a. Facility Name *(If not institution, give street end number)*: Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 213-82-6031

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 29 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 2, 1971

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 6310 Fulmer Road

10f. Zip Code: 21703

10g. Citizen of What Country?: U.S.A.

11. Marital Status: [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Farm Laborer

16b. Kind of Business/Industry: Farming

17. Father's Name *(First, Middle, Last)*: Ralph Baugher

18. Mother's Name *(First, Middle, Maiden Surname)*: Virginia Ellen Hurt

19a. Informant's Name/Relationship *(Type, Print)*: Patricia E. Jewell, Sister

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 5 East "E" Street, Brunswick, Maryland 21716

20a. Method of Disposition: [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Pauls Lutheran Cemetery, Jan. 31, 2001

20c. Location - City or Town, State: Jefferson, Maryland

21. Signature of Funeral Service Licensee: ▶ Richard E. Boyd M00255

22. Name and Address of Facility: Keeney and Basford PA Funeral Home, 106 East Church St., Frederick, Md. 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Respiratory failure

Due to (or as a consequence of):
b. Pleural Effusion

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Ascites

Due to (or as a consequence of):
d. Liver failure

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Alcohol Abuse History

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ David Rossoff MD

29c. License number: D54121

29d. Date signed *(Month, Day, Year)*: 1/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David Rossoff MD 310 W. 9th St. Frederick, MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 30 2001

32. Registrar's Signature: ▶ Debra B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04102

BROWNLOW, Betty

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BETTY GRACE BROWNLOW
2. Date of Death (Month, Day, Year): JAN. 29 2001
3. Time of Death: 3:50PM
4a. Facility Name (If not institution, give street and number): Western Maryland Hospital Center
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 214-32-4154
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 29, 1934
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 221 Braddock Avenue
10f. Zip Code: 21701
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☐ No If Yas, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, Whita, etc. Specify: White

15. Decedent's Education (Specify only highest grada completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Henry Lightner
18. Mother's Name (First, Middle, Maiden Surnama): Helen Grace Gross

19a. Informant's Name/Relationship (Type, Print): Edgar R. Brownlow (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 221 Braddock Avenue, Frederick, Maryland 21701

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mount Olivet Cemetery
Date: 2/1/01
20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Robert E. Dailey
22. Nama and Addrass of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disaase or condition resulting in death): a. Pneumonia — weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immadiate cause. Entar Underlying Cause (Disaase or Injury that initiated events resulting in daath) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.: Respiratory Failure, Ventilator Dependent; Congestive Heart Failure; Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datermined

28a. Data of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to tha causa(s) and manner as stated. 2☐ Medical Examiner: On tha basis of examination and/or investigation, in my opinion, death occurred at the tima, data and place, and due to the cause(s) and manner stated.

29b. Signature and titla of certifier: Rose Marie Chan, M.D.
29c. License number: D76416
29d. Data signed (Month, Day, Year): Jan. 29, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): ROSE MARIE CHAN, M.D. 1500 Pennsylvania Avenue Hagerstown, MD 21742

State Registrar

31. Data filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: Geneva G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04103

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Myrtlen Sheets Burke
2. Date of Death Month Day Year: January 30, 2001
3. Time of Death: 7:50 a.m.
4a. Facility Name *(If not institution, give street and number)*: Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 214-32-2606
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 66 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 21, 1934
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 116 E. 7th Street
10f. Zip Code: 21701
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1957-59
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Technician
16b. Kind of Business/Industry: Vending Machine Co.

17. Father's Name *(First, Middle, Last)*: Howard A. Burke
18. Mother's Name *(First, Middle, Maiden Surname)*: Pearl Viola Sheets

19a. Informant's Name/Relationship *(Type, Print)*: Claudia Burke, wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 116 E. 7th Street, Frederick, MD 21701

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other *(Specify)* Entombment
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Olivet Cemetery — Date: 2/2/2001
20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Ryan M Berger M00999
22. Name and Address of Facility: Keeney and Basford Funeral Home, 106 East Church Street, Frederick, MD 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction — 30 minute
Due to (or as a consequence of):
b. Coronary Artery Disease — 13 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Diabetes mellitus
Chronic Obstructive Pulmonary Disease
Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [✓] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [✓] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Francis E Becker MD
29c. License number: D20496
29d. Date signed *(Month, Day, Year)*: 1/30/2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Francis E. Becker MD; 300 W 9th St; Frederick, MD 21701

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 31 2001
32. Registrar's Signature: Penny D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04104

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: FLORENCE G. CASPER
2. Deta of Death Month / Dey / Yeer: January 24 2001
3. Time of Deeth: 1721
4a Facility Neme *(If not institution, give street and number)*: Suburban Hospital
4b. City, Town, or Location of Deeth: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Sociel Security Number: 218-52-9506
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. lest birthday)*: 53 Yrs. — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: May 21 1947
9. Birthplece *(State or Foreign Country)*: DE

Usuel Residence of Decedent

10a. Stete: MD
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 20701 Bell Bluff Road
10f. Zip Code: 20879
10g. Citizen of Whet Country?: USA

11. Maritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 — College (1-4or 5+):
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: church administrator
16b. Kind of Business/Industry: Church
17. Fether's Neme *(First, Middle, Last)*: Robert Q Gerhard
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Ethel Cowell
19a. Informent's Neme/Reletionship *(Type, Print)*: Keith Casper / husband
19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 20701 Bell Bluff Rd. Gaithersburg, MD 20879
20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Pleca of Disposition *(Neme of cemetery, cremetory or other piece)*: ENDERS/SHIRLEY F.H.
Dete: 1/27
20c. Location - City or Town, State: BERRYVILLE, VA
21. Signature of Funerel Service Licensee: [signature]
22. Neme end Address of Fecility: HILTON FUNERAL HOME BOX 86, BARNESVILLE, MD 20838

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediete Cause (Finel diseese or condition resulting in deeth)
a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Lest
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Was case referred to medicel examiner? 1☒ Yes 2☐ No
26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☒ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2☒ **Medical Examiner:** On the besis of exemination end/or investigetion, in my opinion, deeth occurred et the time, date end pleca, and due to the ceuse(s) and manner stated.
29b. Signature end title of certifier: [signature] CARL I. MARCUS
29c. License number: 015236
29d. Date signed *(Month, Dey, Yeer)*: JANUARY 29, 2001
30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): CARL I. MARCUS, M.D. (DME) 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JAN 29 2001
32. Registrer's Signeture: [signature]

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 23a,ptII per md G792 2/13/01 yf

Certificate of Death

Reg. No. 2001 04105

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Michael Crum
2. Date of Death (Month, Day, Year): January 13, 2001
3. Time of Death: 7:35 AM
4a. Facility Name (If not institution, give street and number): Homewood at Crumland Farms
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 219-36-4217
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 12, 1910
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1 ☐ Yes 2 X No
10e. Street and Number: 7404 Willow Road
10f. Zip Code: 21702
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XX No If Yes, Give Year or Dates: XX
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 XX No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Dairy Farmer
16b. Kind of Business/Industry: Farming

17. Father's Name (First, Middle, Last): John Emory Crum
18. Mother's Name (First, Middle, Maiden Surname): Stella Venolia Michael

19a. Informant's Name/Relationship (Type, Print): Mr. J. Denham Crum, Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7612 Willow Road, Frederick, Maryland 21702

20a. Method of Disposition: XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Mount Hope Cemetery, January 17, 2001
20c. Location - City or Town, State: Woodsboro, Maryland

21. Signature of Funeral Service Licensee: Richard C.C. Basford #00001
22. Name and Address of Facility: Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Maryland 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: 4 days

Immediate Cause (Final disease or condition resulting in death):
a. ATHEROSCLEROTIC HEART DISEASE

Due to (or as a consequence of):
Rectal Bleeding

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
RECTAL BLEEDING
Atherosclerotic Heart Disease

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Casper E. Cline M.D.
29c. License number: D16428
29d. Date signed (Month, Day, Year): January 15, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Casper E. Cline M.D., 300 West Ninth Street, Frederick, Md. 21701

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04106

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lloyd Crockett

2. Date of Death — Month: JANUARY Day: 27 Year: 01

3. Time of Death: 1023

4a. Facility Name (If not institution, give street and number): Northwest Hosp Center

4b. City, Town, or Location of Death: Randallstown

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-22-1859

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 22, 1920

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Ijamsville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 5452 Mussetter Road

10f. Zip Code: 21754

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Farming

16b. Kind of Business/Industry: Farming

17. Father's Name (First, Middle, Last): Frederick Eugene Crockett

18. Mother's Name (First, Middle, Maiden Surname): Maria Wood

19a. Informant's Name/Relationship (Type, Print): Judith Delauter - Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5452 Mussetter Road, Ijamsville, Maryland 21754

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Howard Chapel Cemetery

Date: 2/1/2001

20c. Location - City or Town, State: Mount Airy, Maryland

21. Signature of Funeral Service Licensee: Olin L. Molesworth

22. Name and Address of Facility: Olin L. Molesworth P.A., Funeral Home, 26401 Ridge Road, Damascus, Maryland 20872-0117

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. lung cancer — 2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [/] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [/] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [/] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [/] No

26. Place of Death (Check only one) — Hospital: 1 [/] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [/] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [/] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: TRUNG PHAM MD

29c. License number: D47704

29d. Date signed (Month, Day, Year): 1/27/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TRUNG PHAM Northwest hospital Center, Randallstown MD

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04107

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mable V. Dodd

2. Date of Death Month / Day / Year: January 20, 2001

3. Time of Death: 9:00 PM

4a. Facility Name *(If not institution, give street and number)*: Corsica Hills Nursing Home

4b. City, Town, or Location of Death: Centreville

4c. County of Death: Queen Annes

Funeral Director

5. Social Security Number: 219-07-6716

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 1, 1905

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Queen Annes

10c. City, Town or Location: Church Hill

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 520 Walnut Street

10f. Zip Code: 21623

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Bleck, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 4 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Line Worker

16b. Kind of Business/Industry: Vital Foods Co.

17. Father's Name *(First, Middle, Last)*: UNKNOWN

18. Mother's Name *(First, Middle, Maiden Surname)*: Laura Sparks

19a. Informant's Name/Relationship *(Type, Print)*: Nelson E. Dodd / Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 51 Grays Lane, Magnolia, Delaware 19962

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesterfield Cemetery | Date: 1/27/2001

20c. Location - City or Town, State: Centriville, Md.

21. Signature of Funeral Service Licensee: ▶ John A. Prince

22. Name and Address of Facility: Bennie Smith Funeral Home, 426 Dover Street, Easton, Maryland 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. Cerebral Vascular Accident — 2 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or es e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other signficant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

① Recent Extensive Pneumonia

② Bed sores of leg + heels ③ UTI.

④ Chronic Renal Failure ⑤ Severe Hypoalbuminemia

23b. Did tobacco uaa contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was case referred to medicel examiner? 1☐ Yes 2☑ No

26. Piece of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Phyaician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Madicef Examinar:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29b. Signature and title of certifier: ▶ [illegible], M.D.

29c. License number: D21313

29d. Date signed *(Month, Day, Year)*: 1/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KIN K. WUN, 415 Washington Ave., Chestertown, MD 21620

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 2 9 2001

32. Registrar's Signature: ▶ B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that tha daath certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificata has been signed by the attanding physician end completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours efter death with tha Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Resp. Cannot 01-30-01 9 PM.

Mabel V Dodd

SS# 219-07-6716 DOB 05-01-05

Dr. Wun SAB

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04108

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARTHA VIRGINIA DAVIS
2. Date of Death (Month, Day, Year): January 26, 2001
3. Time of Death: 10:20 PM
4a. Facility Name *(If not institution, give street and number)*: Glade Valley Nursing & Rehabilitation Ctr.
4b. City, Town, or Location of Death: Walkersville
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 220-16-2123
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Apr. 29, 1920
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Walkersville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 56 West Frederick Street
10f. Zip Code: 21793
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Foreman
16b. Kind of Business/Industry: Thurmont Shoe Company

17. Father's Name *(First, Middle, Last)*: Harry N. Redmond
18. Mother's Name *(First, Middle, Maiden Surname)*: Myrtle V. Garver

19a. Informant's Name/Relationship *(Type, Print)*: Nancy Y. McCorkle (Daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 325, Thurmont, Maryland 21788

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Blue Ridge Cemetery
Date: 1/30/01
20c. Location - City or Town, State: Thurmont, Maryland

21. Signature of Funeral Service Licensee: Robert E. Dailey Jr
22. Name and Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN STREET, THURMONT, MD 21788

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. COPD	years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Alzheimers disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Allen J. Gilson MD
29c. License number: D26546
29d. Date signed *(Month, Day, Year)*: JAN 29 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Allen J. Gilson, MD 1475 Taney Avenue, Frederick, Maryland 21701

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 3 0 2001
32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04109

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ONEIDA BELL EYLER
2. Date of Death (Month, Day, Year): January 28, 2001
3. Time of Death: 6:05 AM
4a. Facility Name (If not institution, give street and number): Glade Valley Nursing & Rehabilitation Ctr.
4b. City, Town, or Location of Death: Walkersville
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 217-42-9254
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 31, 1911
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Walkersville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 56 West Frederick Street
10f. Zip Code: 21793
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decadant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highast grada complatad): Elamantary/Secondary (0-12): 7 | Collega (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired): Seamstress
16b. Kind of Business/Industry: Sewing Factory

17. Fathar's Nama (First, Middla, Last): William Welty
18. Mothar's Nama (First, Middla, Maidan Sumama): Nettie Clem

19a. Informant's Name/Raletionship (Type, Print): Josephine Dinterman (Daughter)
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 11019 Rocky Ridge Rd., Keymar, Maryland 21757

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Ramoval from Stata 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Nama of cematary, cramatory or othar place): Mt. Tabor Cemetery
Data: 1/31/01
20c. Location - City or Town, Stata: Rocky Ridge, Maryland

21. Signature of Funeral Service Licensee: Robert E. Dailey
22. Name and Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN STREET, THURMONT, MD 21788

Physician /Medical Examiner

23a. Part I. Enter the disease, or complication that caused the death. Do not entar the moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ona cause on each line.

Approximate Intarval Between Onset and Death

Immediate Cause (Final disaasa or condition rasulting in daath)
a. ASCVD — 10 yrs
Dua to (or as a consequence of):
Sequentially list conditions, if any, leading to immadiate cause. Entar Underlying Cause (Disaase or Injury thet initiated avants rasulting in daath) Last
b.
Dua to (or as a consequance of):
c.
Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to daath but not rasulting in the underlying causa given in Part I.
STROKE
CHF -

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Wara autopsy findings available prior to complation of cause of death? 1☐ Yes 2☒ No

25. Was cese referred to medicat examinar? 1☐ Yas 2☒ No
26. Place of Daath (Check only ona): Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Rasidence 6☐ Othar (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be determined
28a. Data of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifiar (Check only one): 1☒ **Certifying Physician**: To tha best of my knowledga, daath occurrad at tha tima, data and place, and dua to the causa(s) and mannar as stated. 2☐ **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at the tima, date and place, and due to the ceuse(s) and mannar stated.
29b. Signatura and title of certifier:
29c. License number: D-31912
29d. Date signed (Month, Day, Year): 1/29/01

30. Nama and address of person who complatad causa of daath (Item 23a) (Type, Print): J.J. Menocal, MD 1564 Opossumtown Pike, Frederick, Maryland 21701

State Registrar

31. Data filed (Month, Day, Year): JAN 30 2001
32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pagas 1 and 2 should be filed within 72 hours after daath with the Maryland Department of Haalth and Mental Hygiena. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic avent, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the daath cartificata be executed within 24 hours after daath.
To the Funeral Director: After this certificate has been signed by tha attanding physician and completely filled in by the funaral director, paga 2 should be datached for usa as tha burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04110

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GEORGE N. FAIRBANKS
2. Date of Death Month / Day / Year: JANUARY 26, 2001
3. Time of Death: 1430
4a. Facility Name *(If not institution, give street and number)*: TALBOT HOSPICE HOUSE
4b. City, Town, or Location of Death: EASTON
4c. County of Death: TALBOT

Funeral Director

5. Social Security Number: 220-16-7528
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 77 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MARCH 30, 1923
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: TALBOT
10c. City, Town or Location: TRAPPE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 29345 GREENFIELD AVENUE
10f. Zip Code: 21673
10g. Citizen of What Country?: U.S.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 44-46
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 — College (1-4or 5+): -0-
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MAINTENANCE MAN
16b. Kind of Business/Industry: POULTRY INDUSTRY

17. Father's Name *(First, Middle, Last)*: JOSEPH FAIRBANKS
18. Mother's Name *(First, Middle, Maiden Surname)*: LILLIAN FAULKNER

19a. Informant's Name/Relationship *(Type, Print)*: LEE FAIRBANKS / WIFE
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. BOX 12 TRAPPE, MD 21673

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MD. VETERANS CEMETERY
Date: JAN.29,2001
20c. Location - City or Town, State: HURLOCK, MD

21. Signature of Funeral Service Licensee: ▶ M. Ed Newnam III C.F.S.P.
22. Name and Address of Facility: FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME 200 S. HARRISON ST. EASTON, MD. 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Metastatic Carcinoma of Stomach — 7 months
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Chronic Obstructive Lung Disease
Degenerative Joint Disease of Spine

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) TALBOT HOSPICE HOUSE

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ William H. Wood Jr.
29c. License number: D08715
29d. Date signed *(Month, Day, Year)*: 1/28/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): WILLIAM H. WOOD, JR., M.D. 505 DUTCHMANS LANE EASTON, MD 21601

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 29 2001
32. Registrar's Signature: ▶ [illegible] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04111

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: J. T. Garman

2. Date of Death — Month: January; Day: 30; Year: 2001

3. Time of Death: 5:54PM

4a. Facility Name *(If not institution, give street and number)*: Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 227-10-7890

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 85 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 23, 1915

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 7951 Yellow Springs Road

10f. Zip Code: 21702

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: March 1945 to Dec. 1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 2

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Business owner

16b. Kind of Business/Industry: Service Station

17. Father's Name *(First, Middle, Last)*: George E. Garman

18. Mother's Name *(First, Middle, Maiden Surname)*: Nora Shepherd

19a. Informant's Name/Relationship *(Type, Print)*: Mary Y. Garman/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7951 Yellow Springs Rd., Frederick, Md. 21702

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Smithsburg Crematory — Date: Jan. 31,

20c. Location - City or Town, State: 2001 Smithsburg, Md.

21. Signature of Funeral Service Licensee: Richard C.C. Basford MD0021

22. Name and Address of Facility: Keeney & Basford Funeral Home, 106 East Church Street, Frederick, Md. 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Pulmonary Edema — 1 Hour

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Stroke — 1 Hour

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D43091

29d. Date signed *(Month, Day, Year)*: 1-30-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAEED ZAHDI 801 TOLL HOUSE AVE, FREDERICK, MD 21701

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 3 1 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04112

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Frank Sharretts Griffin
2. Date of Death (Month, Day, Year): January 31, 2001
3. Time of Death: 9:40 P.M.
4a. Facility Name *(If not institution, give street and number)*: Homewood Retirement Center
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 214-10-4082
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 95 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 7, 1905
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7407 Willow Road
10f. Zip Code: 21702
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 — College (1-4 or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Monument Dealer
16b. Kind of Business/Industry: Monument Sales/Service

17. Father's Name *(First, Middle, Last)*: William H. Griffin
18. Mother's Name *(First, Middle, Maiden Surname)*: Jane Thomas

19a. Informant's Name/Relationship *(Type, Print)*: Philip W. Hammond/P.O.A.
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 438 West Patrick Street, Frederick, Maryland 21701

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mount Olivet Cemetery — Date: February 3, 2001
20c. Location - City or Town, State: Frederick, Md.

21. Signature of Funeral Service Licensee: Richard C.C. Basford M00021
22. Name and Address of Facility: Keeney & Basford Funeral Home, 106 East Church Street, Frederick, Maryland

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive heart failure — 6-8 years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Robert S Hughes
29c. License number: D05111
29d. Date signed *(Month, Day, Year)*: February 1, 2001
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Robert S. Hughes, M.D., 700 Montclaire Avenue, Frederick, Maryland 21701

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 02 2001
32. Registrar's Signature: Bonnie B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04113

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anna Deen Harper
2. Date of Death Month: January Day: 31 Year: 2001
3. Time of Death: 1456
4a. Facility Name (If not institution, give street and number): Kent & Queen Anne's Hospital, Inc.
4b. City, Town, or Location of Death: Chestertown
4c. County of Death: Kent

Funeral Director

5. Social Security Number: 215-14-3808
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 7, 1916
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD. 10b. County: KENT 10c. City, Town or Location: CHESTERTOWN 10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 222 WASHINGTON STREET 10f. Zip Code: 21620 10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE

16b. Kind of Business/Industry: HOUSEWIFE

17. Father's Name (First, Middle, Last): CARL ROSS DEEN

18. Mother's Name (First, Middle, Maiden Surname): NELLIE VICKERS

19a. Informent's Name/Relationship (Type, Print): DONALD F. HARPER - SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 222 WASHINGTON ST. CHESTERTOWN, MD.

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): CAPITAL CREMATORY Date: 02/01/01

20c. Location - City or Town, State: DOVER, DE.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: WILLIAMSON FUNERAL HOME FREDERALSBURY, MD. 21632

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
e. Lower GI bleed — >2wks

Due to (or as e consequenca of):
b. Pneumia & Sepsis — >2wks

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequenca of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
- Rhabdomyolysis

23b. Did tobacco use contributa to the causa of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☑ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end manner es stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) and manner stated.

28b. Signature and title of certifier: [signature]
29c. License number: D3605Y
29d. Date signed (Month, Day, Year): 2/1/01

30. Nema and address of person who completed causa of daath (Item 23a) (Type, Print): PATRICIA J. SHARMAN 120 Green Rd CHESTERTN md 21620

State Registrar

31. Dete filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signatura: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04114

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ok Soon Hwang
2. Date of Death Month / Day / Year: February 3 2001
3. Time of Death: ~11 AM
4a. Facility Name *(If not institution, give street and number)*: Howard County General Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 212 31 3147
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 95 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Apr 17, 1905
9. Birthplace *(State or Foreign Country)*: Korea

Usual Residence of Decedent

10a. State: MD
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9991 Old Mill Road
10f. Zip Code: 21042
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Korean

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): unknown; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: unknown
18. Mother's Name *(First, Middle, Maiden Surname)*: unknown

19a. Informant's Name/Relationship *(Type, Print)*: Young Hee Lee/Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9991 Old Mill Road Ellicott City, MD 21042

20a. Method of Disposition: ☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Crest Lawn Cemetery — Date: 2-5-2001
20c. Location - City or Town, State: Marriottsville, MD

21. Signature of Funeral Service Licensee: MD1044 Dena Allis-Wolfe
22. Name and Address of Facility: Harry H. WItzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in deeth): e. Atherosclerotic Cardiovascular Disease — Years

Due to (or as e consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in death) Last:
b.
Due to (or es a consequence of):
c.
Due to (or as e consequenca of):
d.

Part II. **Other eignificant conditione** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco uee contribute to the cauee of deeth?** 1☐ **Yee** 2☒ **No** 3☐ **Probably** 4☐ **Unknown**

24e. Wes en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Phyeician**: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end manner es stated. 2☒ **Medical Examiner**: On the basis of exemination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Patryce A. Toye, MD Deputy ME
29c. License number: D31473
29d. Date signed *(Month, Dey, Yeer)*: Feb 4, 2001

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print): PATRYCE A. TOYE, MD 4565 Hemlock Cone Way Ellicott City MD 21042

State Registrar

31. Dete filed *(Month, Day, Year)*: FEB 05 2001
32. Registrar's Signeture: G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(1)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04115

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CHESTER LANE HAYNES
2. Date of Death Month Day Year: January 26, 2001
3. Time of Death: 1519 PM
4a. Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 233-64-1137
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 60 Yrs. If Under 1 Yaar: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan. 10, 1941
9. Birthplace *(State or Foreign Country)*: West Virginia

To Be Completed by Funeral Director

Usual Residence of Decedant

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Thurmont
10d. Inside City Limits: 1 [X] Yas 2 [ ] No
10e. Street and Number: 203 North Carroll Street
10f. Zip Coda: 21788
10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Evar in U,S. Armed Forces? 1 [ ] Yas 2 [X] No If Yas, Giva Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - Amaricen Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elamentary/Secondery (0-12): 12; Collega (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratirad)*: Groundskeeper
16b. Kind of Business/Industry: Lakewood Country Club

17. Father's Nama *(First, Middla, Last)*: Clyde F. Haynes
18. Mothar's Name *(First, Middle, Maiden Surnama)*: Posey Unknown

19a. Informant's Name/Ralationship *(Type, Print)*: Barbara G. Haynes (Wife)
19b. Mailing Addrass *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 203 North Carroll Street, Thurmont, Maryland 21788

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar *(Specify)*
20b. Place of Disposition *(Nama of cematary, cramatory or othar placa)*: Blue Ridge Cemetery
Data: 1/30/01
20c. Location - City or Town, Stata: Thurmont, Maryland

21. Signatura of Funaral Service Licensee: Robert E. Dailey Jr.
22. Name and Addrass of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN STREET, THURMONT, MD 21788

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or raspiretory errest, shock, or heart failura. List only one cause on each line.

		Approximata Intarval Batwean Onset and Death
Immediata Causa (Final diseasa or condition resulting in daath) a.	Massive Cerebral Infarct	days
Dua to (or as a consequence of): b.	Massive Cerebral Edema	days
Sequentially list conditions, if any, leading to immediata cause. Enter Undarlying Causa (Diseasa or injury that initieted events resulting in death) Last Due to (or es e consequence of): c.	Hypertension	years
Due to (or as e consequence of): d.	Cerebral Vasculitis	months

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying ceusa givan in Part I.

23b. Did tobacco uee contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an eutopsy performed? 1 [ ] Yas 2 [X] No

24b. Wara autopsy findings available prior to completion of causa of death? 1 [ ] Yas 2 [ ] No

25. Was cesa rafarred to medicet examinar? 1 [ ] Yes 2 [X] No

26. Piece of Deeth *(Check only ona)*: Hospital: 1 [X] Inpatiant 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Homa 5 [ ] Rasidence 6 [ ] Othar *(Specify)*

27. Mennar of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Pending Invastigetion 6 [ ] Could not be datermined

28a. Place of Injury - At homa, farm, straat, factory, office building, etc. *(Specify)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Dascribe how injury occurred
28e. Data of Injury *(Month, Day Year)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To tha best of my knowledga, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to tha ceuse(s) and mannar stetad.

29b. Signatura and title of certifiar: Efobi, Anthony U. MD.
29c. Licensa number: D0048144
29d. Data signed *(Month, Day, Year)*: January 26, 2001

30. Nama and addrass of person who completed ceusa of death (Item 23a) (Type, Print): Efobi, Anthony, U.MD, Shady Grove Adventist Hospital, Rockville, Maryland

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 3 0 2001
32. Registrar's Signatura: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04116

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Merhle Lighter Ifert

2. Deta of Death — Month: January Day: 25 Year: 2001

3. Time of Death: 11:52 AM

4a Facility Name (If not institution, give street end number): Frederick memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Sociel Security Number: 217-30-5441

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 85 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): July 24, 1915

9. Birthpleca (State or Foreign Country): MD

Usuet Residenca of Decedent

10a. State: MD

10b. County: Frederick

10c. City, Town or Location: Middletown

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street end Number: 3511 Bussard Rd.

10f. Zip Code: 21769

10g. Citizen of Whet Country?: USA

11. Maritel Stetus: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Evar in U,S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Rece - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementery/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): farmer

16b. Kind of Business/Industry: farm owner

17. Fathar's Neme (First, Middle, Last): Ira D. Ifert

18. Mother's Name (First, Middle, Maiden Surneme): Zora Lighter

19a. Informent's Name/Reletionship (Type, Print): Ruth Ellen Burrier (Sister)

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 7800 Picnic Woods Rd., Middtown, MD 21769

20a. Method of Disposition: 1☒Buriel 2☐Cramation 3☐Removel from Stete 4☐Donation 5☐Other (Specify)

20b. Pleca of Disposition (Neme of cemetery, cremetory or other piece): Lutheran Cemetery

Dete: 1/28

20c. Location - City or Town, Stete: Middletown, MD

21. Signature of Funaral Service Licensee: Donald B. Thompson

22. Neme and Address of Facility: Donald B. Thompson Funeral Home, 31 E. Main St., MIddletown, MD 21769

Physician /Medical Examiner

23. Part I. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediete Ceuse (Finat diseese or condition resulting in death): e. LEFT LOWER LOBE PNEUMONIA — 1 WEEK

Due to (or es a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest

b.

Due to (or es e consequenca of):

c.

Dua to (or as e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Wes en eutopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings eveileble prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Piece of Death (Check only one) — Hospitel: 1☒Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☐Residenca 6☐Other (Specify)

27. Menner of Death: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒**Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2☐**Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, and due to the ceuse(s) and menner steted.

29b. Signeture end title of certifier: W. Mgair M.D.

29c. License number: D16675

29d. Dete signed (Month, Day, Year): 1/26/01

30. Nema and address of person who completed cause of death (Item 23a) (Type, Print): WAYNE KLIGHER, BRUNSWICK, MD 21716

State Registrar

31. Dete filed (Month, Day, Year): JAN 29 2001

32. Registrer's Signetura: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04117

Allan Isensee February 2, 2001 03104

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Allan R. Isensee	February 2, 2001	3:10 A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Gilchrist Center	Towson	Baltimore

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	If Under 1 Year: Days	If Under 24 Hrs.: Hours	If Under 24 Hrs.: Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
398-38-8607	1☒M 2☐F	61 Yrs.					Dec. 25, 1939	Wisconsin

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Howard	Clarksville	1☐Yes 2☒No

10a. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11485 Johns Hopkins Rd.	21029	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4 or 5+)		
	5+	Research Scientist	U.S. Dept. of Agriculture

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Herman Isensee	Genevieve Peterson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Helen Isensee / spouse	11485 Johns Hopkins Rd. Clarksville, MD. 21029

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Metro Crematory	Feb. 5 2001	Catonsville, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
M01092	Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD. 21043

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute Leukemia	8 months
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☑No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Hospice

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ W. Anthony Riley, MD	D25205	February 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. A. Riley GBMC 6701 N. Charles St. Balto. Md 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 05 2001	▶ B. Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

(10)

Caf

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04118

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Tyrone Anthony Jolley

2. Date of Death Month: January Dey: 17 Year: 2001

3. Time of Death: 5:15 PM

4a. Facility Name (If not institution, give street and number): 4727 Corkran Cemetery Road

4b. City, Town, or Location of Death: Hurlock

4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 214-66-8256

8. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 44 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): April 7, 1956

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Dorchester

10c. City, Town or Location: Hurlock

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4727 Corkran Cemetery Road

10f. Zip Code: 21643

10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Janitor

16b. Kind of Business/Industry: Eastern Shore Hospital

17. Father's Name (First, Middle, Last): Clarence Davis, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Geneva Jolley

19a. Informant's Name/Relationship (Type, Print): Geneva Davis / Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O.Box 353 , Hurlock,Maryland 21643

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Petersburg Cemetery

Date: 1/24/2001

20c. Location - City or Town, State: Hurlock,Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Bennie Smith Funeral Home 426 Dover Street,Easton,Maryland 21601

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Interval Between Onset end Death

Immediate Ceuse (Finel diseese or condition resulting in death) e. Lung Cancer — Months

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in death) Lest

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the causa of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was en eutopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [ ] No

26. Place of Deeth (Check only one) Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury el Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1 [ ] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) and manner es steted. 2 [ ] **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) end manner steted.

29b. Signeture and title of certifier: [signature]

29c. License number: 027345

29d. Date signed (Month, Dey, Year): 1/28/01

30. Neme and address of person who completed ceuse of deeth (Item 23e) (Type, Print): Howard M. Haft, MD, 700 Old Line Center, Suit 100, Leonardtown Rd, 20602 Waldorf, Md.

State Registrar

31. Dete filed (Month, Dey, Year): JAN 29 2001

32. Registrer's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

SBB

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04119

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Harold F. Jones III
2. Date of Death (Month, Day, Year): January 29, 2001
3. Time of Death: 5:50 pm
4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 215-54-7030
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 51 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 29, 1949
9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Mt. Airy
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 204 Westridge Drive
10f. Zip Code: 21771
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1967-73
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electronic Engineer
16b. Kind of Business/Industry: County Government

17. Father's Name (First, Middle, Last): Harold F. Jones Jr.
18. Mother's Name (First, Middle, Maiden Surname): Mary Rose Gallagher

19a. Informant's Name/Relationship (Type, Print): Janet F. Jones/ Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 204 Westridge Drive, Mt. Airy, Maryland 21771

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematorium — Date: 2/3/2001
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Todd O Wynn
22. Name and Address of Facility: Olin L. Molesworth P. A. , Funeral Home 26401 Ridge Road, Damascus, Maryland 20872

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Arteriosclerotic Cardiovascular Disease — Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Andrew Zarick
29c. License number: D35164
29d. Date signed (Month, Day, Year): January 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andrew Zarick, Jr, M.D., 1080 West Patrick Street, Frederick, Maryland 21703

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04120

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SISTER MARY ANN LEWIS
2. Date of Death Month / Dey / Year: FEBRUARY 2, 2001
3. Time of Death: 8:20 A.M.
4a Facility Name *(If not institution, give street end number)*: ST. VINCENT CARE CENTER
4b. City, Town, or Location of Death: EMMITSBURG
4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 095-40-1191
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 95 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: JAN.10,1906
9. Birthplace *(Stete or Foreign Country)*: MARYLAND

Usuel Residence of Decedant

10a. Stete: MD
10b. County: FREDERICK
10c. City, Town or Location: EMMITSBURG
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 335 S. SETON AVE.
10f. Zip Code: 21727
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☒ Never Merried 2☐ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indian, Black, Whita, atc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grede completed)*: Elemantary/Secondery (0-12): — College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: TEACHER
16b. Kind ot Business/Industry: RELIGIOUS COMMUNITY DAUGHTERS OF CHARITY

17. Fether's Neme *(First, Middle, Last)*: ROGER EDMUND LEWIS
18. Mothar's Nema *(First, Middle, Maidan Surname)*: MARY GERTRUDE LOWE

19e. Informant's Name/Reletionship *(Type, Print)*: SISTER CAMILLA HARANT/SUPERIOR
19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 333 S. SETON AVE., EMMITSBURG, MD. 21727

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Plece of Disposition *(Neme of cemetary, crematory or other place)*: ST. JOSEPH'S P. H. — Deta: 2/6/01
20c. Location - City or Town, State: EMMITSBURG, MD. 21727

21. Signeture of Funeral Service Licensaa: John M. Skiles
22. Name and Address of Facility: SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or raspiretory arrest, shock, or haert tailura. List only one causa on each lina.

Approximata Intarvel Between Onset end Deeth

Immediate Cause (Final diseese or condition resulting in death)
a. Congestive Heart Failure — 10 years

Due to (or as a consequence of):
b. Atherosclerotic and Valvular Heart Disease — >11 years

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or injury that initeted events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: Chronic atrial fibrillation

23b. Did tobacco uae contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigetion 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, atc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et tha time, data and place, and dua to tha causa(s) and mannar stated.

29b. Signeture end title of certifier: Alan Carroll MD
29c. License number: D18705
29d. Date signed *(Month, Day, Year)*: FEBRUARY 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALAN CARROLL, M.D., 310 S. SETON AVE., EMMITSBURG, MD. 21727

State Registrar

31. Dete filed *(Month, Day, Year)*: FEB 02 2001
32. Registar's Signeture: Denise D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funerel director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 04121

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Betty E. Laurence
2. Date of Death (Month, Day, Year): January 27, 2001
3. Time of Death: 6:35 pm
4a. Facility Name (If not institution, give street and number): Apt. 6, 203 High Street
4b. City, Town, or Location of Death: Cambridge
4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 147-12-9702
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Yeer): Sept. 15, 1924
9. Birthplace (State or Foreign Country): Unknown

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Dorchester
10c. City, Town or Location: Cambridge
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: Apt. 6, 203 High Street
10f. Zip Code: 21613
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Caregiver
16b. Kind of Business/Industry: Health Care

17. Father's Name (First, Middle, Last): William M. Bradley, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Wilsie Earl

19a. Informant's Name/Relationship (Type, Print): L. Thomas Kuhn / P.R.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 203 High St., Cambridge, MD 21613

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cambridge Crematory
Date: 01-31-01
20c. Location - City or Town, State: Cambridge, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or hear failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Emphysema	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. **Did tobacco use contribute to tha cause of death?** 1☑ **Yes** 2☐ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Was en autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Phyaician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jay D Kerr MD
29c. License number: D54840
29d. Date signed (Month, Dey, Year): 1/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jay D. Kerr, MD 503A Muir Street, Cambridge, MD 21613

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001
32. Registrar's Signature: [signature] G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04122

Margaret McCrea SS# 223,42 8439

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARGARET ROGERS McCREA
2. Deta of Deeth (Month, Dey, Yeer): January 25 2001
3. Time of Death: 1645
4a. Facility Neme *(If not institution, give street end number)*: PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 223-42-8439
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 84 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: SEPT. 7, 1916
9. Birthplece *(Stete or Foreign Country)*: SC

Usuel Residence of Decedent

10a. Stete: MD
10b. County: TALBOT
10c. City, Town or Location: ROYAL OAK
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 7051 THORNETON RD
10f. Zip Code: 21662
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaer or Datas:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - Americen Indien, Black, White, etc. *Specify:* WHITE
15. Decedent's Eduction *(Specify only highest greda completed)*: Elementery/Secondery (0-12): 11; College (1-4or 5+): 4
16a. Decedent's Usuel Occupetion *(Give kind of work done duning most of working life. DO NOT use retired)*: EDUCATOR
16b. Kind of Business/Industry: PUBLIC SCHOOL
17. Fathar's Neme *(First, Middle, Last)*: DANIEL D. ROGERS
18. Mother's Neme *(First, Middle, Maiden Surneme)*: LAURA LAVADA TEMPLETON
19a. Interment's Name/Relationship *(Type, Print)*: THOMAS E. McCREA/SON
19b. Meiling Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 27975 WOODS RD., EASTON, MD 21601
20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: PRIVATE FAMILY CEMETERY
Dete: 1-30-01
20c. Location - City or Town, Stete: PRESTON, MD
21. Signature of Funeral Service Licensee: M. E. Newnam III C.F.S.P.
22. Nama and Address of Facility: FELLOWS, HELFENBEIN &NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on eech line. (Approximete Interval Between Onset end Deeth)

Immediete Ceuse (Finel diseese or condition resulting in death): a. Myocardial Infarction with Ventricular Septal Defect

Due to (or as e consequence of):

Sequentially list conditions, if any, leeding to immediete ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last:
b.
Due to (or es e consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: End Stage Renal Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☐ Neturel 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, tactory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier:

29c. License number: D40715

29d. Date signed *(Month, Day, Year)*: 1/27/01

30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print): Steven Hearne 106 Milford Street Salisbury md 21804

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JAN 29 2001

32. Registrar's Signature: D. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04123

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Francis McAleavy

2. Data of Death: Month January Day 26, Year 2001

3. Time of Death: 3:00 pm

4a. Facility Name (If not institution, give street and number): 6902 Greenvale Court

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 262-50-7504

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 64 Yrs. | If Under 1 Yaar: Months / Days | If Undar 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Yaer): Mar 22, 1936

9. Birthplaca (State or Foraign Country): Florida

Usual Rasidance of Decedant

10a. Stata: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1☐ Yas 2☒ No

10a. Street and Number: 6902 Greenvale Court

10f. Zip Coda: 21702

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Navar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Dacedent Evar in U.S. Armed Forcas? 1☒ Yes 2☐ No If Yes, Giva Yaar or Datas: 1956-1962

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Ricen, atc.) 1☐ Yes 2☒ No Specify:

14. Race - Americen Indien, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elamantary/Secondary (0-12) / Collega (1-4or 5+): 4

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): Budget Analyst

16b. Kind of Businass/Industry: Dept of Agriculture

17. Fether's Nama (First, Middla, Last): Patrick Joseph McAleavy

18. Mothar's Nama (First, Middla, Maidan Surnama): Grace Leddy Kelly

19a. Informant's Name/Ralationship (Type, Print): Lorraine McAleavy , Wife

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 6902 Greenvale Court, Frederick, Maryland 21702

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Nama of cemetery, crematory or othar place): St. Peter's Cemetery

Data: Jan 30, 2001

20c. Location - City or Town, State: Libertytown, MD

21. Signature of Funeral Service Licensee: Keith Lynn Roberson M00706

22. Name and Address of Facility: Keeney & Basford P.A. Funeral Home, 106 East Church St, Frederick, Maryland 21701

Physician /Medical Examiner

23a. Part I. Enter the diseasa, or complications that ceused tha death. Do not enter tha moda of dying, such as cerdiac or raspiratory arrast, shock, or heart failure. List only ona cause on eech line.

Approximata Intervel Between Onsat and Death

Immediata Ceuse (Final diseesa or condition resulting in daath)
e. CHRONIC LYMPHOCYTIC LEUKEMIA — 5 YEARS

Dua to (or as a consequance of):

Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Causa (Disaasa or injury that initiated evants resulting in deeth) Lest
b.

Dua to (or as a consequance of):
c.

Due to (or es e consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa given in Part I.: CARDIOMYOPATHY

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings availabla prior to completion of cause of daath? 1☐ Yas 2☒ No

25. Was cesa rafarred to medical axaminar? 1☐ Yas 2☒ No

26. Placa of Death (Chack only one): Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Homa 5☒ Residence 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Dascribe how injury occurred

28e. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1☒ Certifying Physician: To tha best of my knowledga, daath occurrad at tha tima, data and place, and dua to tha causa(s) and mannar es stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and due to tha causa(s) and mannar stated.

29b. Signature and title of certifier: Brian M. O'Connor MD

29c. License number: D31761

29d. Date signed (Month, Day, Year): January 27, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Brian M. O'Connor, M.D., 500 West Seventh Street, Frederick, Maryland 21701

State Registrar

31. Data filed (Month, Day, Year): JAN 29 2001

32. Registrar's Signatura: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04124

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RAYMOND LEE NALLEY, SR.

2. Date of Death (Month, Day, Year): January 26, 2001

3. Time of Death: 6:05 p.m.

4a. Facility Name (If not institution, give street and number): 4209 Basford Road

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 215-42-3968

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 57 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 11, 1943

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 4209 Basford Road

10f. Zip Code: 21703

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - Amarican Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Loader Operator

16b. Kind of Business/Industry: Stone Company

17. Father's Name (First, Middle, Last): Arnold Fillmore

18. Mother's Name (First, Middle, Maiden Surname): Louise F. Virts

19a. Informant's Name/Relationship (Type, Print): Barbara Jean Nalley/ wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4209 Basford Rd. / Frederick, Maryland 21703

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Resthaven Memorial Cem. | Date: 01-31-01

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Raymond Peterson

22. Name and Address of Facility: Stauffer Funeral Home, 1621 Opossumtown Pike/ Frederick, MD 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. METASTATIC POORLY DIFFERENTIATED SARCOMA — 2 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated. 2 ☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Brian M. O'Connor, MD

29c. License number: D31761

29d. Date signed (Month, Day, Year): 1/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BRIAN M. O'CONNOR, MD 501 W. SEVENTH ST., FREDERICK, MD 21701

State Registrar

31. Data filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04125

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Tell William Nicolet Jr.
2. Date of Deeth — Month: January; Dey: 29,; Year: 2001
3. Time of Death: 12:00 PM
4a. Facility Name *(If not institution, give street end number)*: 11240 Kingstead Road
4b. City, Town, or Location of Deeth: Damascus
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 216-18-8835
6. Sex: 1☒M 2☐F
7. Age *(In yrs. lest birthdey)*: 78 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Dey, Year)*: October 16, 1922
9. Birthplace *(Stete or Foreign Country)*: Pennsylvania

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Montgomery
10c. City, Town or Location: Damascus
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 11240 Kingstead Road
10f. Zip Code: 20872
10g. Citizan of What Country?: U.S.A.

11. Maritel Status: 1☐Nevar Married 2☒Merried 3☐Widowed 4☐Divorced
12. Was Decedant Ever in U,S. Armed Forces? 1☐Yes 2☐No If Yes, Give Year or Detas: WWII
13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - Amarican Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12); College (1-4or 5+): 2
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use ratired)*: Draftsman
16b. Kind of Business/Industry: Civil Engineering

17. Fathar's Neme *(First, Middle, Last)*: Tell William Nicolet, Sr.
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Phyllis Cogswell

19a. Informant's Neme/Reletionship *(Type, Print)*: Etta Nicolet - Wife
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 11240 Kingstead Road, Damascus, Maryland 20872

20a. Mathod of Disposition: 1☐Buriel 2☒Cremetion 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, crematory or other piece)*: Metropolitan Crematorium
Dete: 1/31/2001
20c. Location - City or Town, Stete: Alexandria, Virginia

21. Signature of Funeral Service Licensee: ▶ Robert L Williams
22. Nama and Address of Facility: Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one cause on eech line.

Approximete Intervel Between Onset end Death

Immediete Cause (Finel disease or condition resulting in death): e. MYOCARDIAL INFARCTION — Approx. Interval: several hours

Due to (or es a consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Last:
b.
Due to (or es a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC RENAL FAILURE; PERIPHERAL VASCULAR disease

23b. Did tobacco use contribute to the cauee of death? 1☐Yee 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 1☐Yes 2☐No

25. Wes case referred to medical examiner? 1☐Yes 2☒No

26. Piece of Deeth *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpetient 3☐DOA; Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*

27. Menner of Deeth: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Streat and Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒**Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es stated. 2☐**Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) and menner steted.

29b. Signeture and title of certifier: ▶ Philip Schwartz M.D.
29c. License number: 024398
29d. Date signed *(Month, Day, Year)*: January 30, 2001

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): 15225 Shady Grove Rd Suite 302 Rockville, MD 20850 Philip Schwartz MD

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 01 2001
32. Registrar's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04126

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ELIZABETH MORRIS PARRISH
2. Date of Death (Month, Day, Year): JANUARY 26, 2001
3. Time of Death: 1:10 P.M.
4a. Facility Name *(If not institution, give street and number)*: Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 256-04-7554
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 43 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov. 15, 1957
9. Birthplace *(State or Foreign Country)*: Georgia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1825 Millstream Drive
10f. Zip Code: 21702
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): ; College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Self Employed
16b. Kind of Business/Industry: Day Care

17. Father's Name *(First, Middle, Last)*: Vilas Edward Morris
18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth Celeste Crosby

19a. Informant's Name/Relationship *(Type, Print)*: Dennis N. Parrish / Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1825 Millstream Drive Frederick, Maryland 21702

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Memorial Gardens
Date: Jan 20 2001
20c. Location - City or Town, State: Statesboro, Georgia

21. Signature of Funeral Service Licensee: D. Fortner
22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only one* cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. transient ischial + subfalcine herniation

Due to (or as a consequence of):
b. large left middle cerebral

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. thrombotic infarction

Due to (or as a consequence of):
d. atherosclerosis

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
tobacco use

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of ~~my knowledge~~, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D35322
29d. Date signed *(Month, Day, Year)*: 2/2/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Konrad W. Bakker 172 Thomas Johnson Drive Frederick, MD 21702

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 0 8 2001
32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04127

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Marie Elizabeth Proctor
2. Data of Death Month / Day / Yaar: January 30 2001
3. Tima of Death: 12:30 a.m.
4a. Facility Nama *(If not institution, giva street and number)*: Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Sacurity Numbar: 219-12-2449
6. Sax: 1☐ M 2☒ F
7. Aga *(In yrs. last birthday)*: 77 Yrs.
If Undar 1 Yaar: Months / Days
If Undar 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Yaar)*: Aug. 23, 1923
9. Birthplaca *(State or Foraign Country)*: Maryland

Usual Rasidance of Decedent

10a. Stata: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Insida City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 4407 Buckeystown Pike
10f. Zip Code: 21704
10g. Citizan of What Country?: United States

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowad 4☐ Divorcad
12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Give Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1☐ Yas 2☒ No *Specify:*
14. Race - Amarican Indian, Black, Whita, atc. *Specify:* Black

15. Decedent's Education *(Specify only highast grada compliatad)*: Elamentary/Secondary (0-12): 12; Collega (1-4or 5+): 1
16a. Dacedant's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT usa ratirad)*: homemaker
16b. Kind of Business/Industry: own home

17. Fathar's Nama *(First, Middla, Last)*: Lloyd Brown
18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Marie Lee

19a. Informant's Name/Ralationship *(Type, Print)*: Betty Bumbray / daughter
19b. Mailing Address *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 9611 Wedgewood Dr., Ft. Washington, MD 20744

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Nama of cematary, cramatory or othar place)*: Hopehill Cemetery
Data: 2/3/01
20c. Location - City or Town, Stata: Hopeland, Maryland

21. Signatura of Funaral Sarvica Licensaa: Jacqueline L Klee
22. Nama and Addrass of Facility: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complicetions that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only ona cause on each line. — Approximata tnterval Batwaan Onsat and Daath

Immediata Causa (Final disaasa or condition resulting in death)
a. Aortic Stenosis
Dua to (or as a consaquanca of):
b.
Dua to (or as a consaquanca of):
c.
Dua to (or as a consaquanca of):
d.

Saquantially list conditions, if any, laading to immadiata ceusa. Entar Underlying Cause (Disease or injury that initiatad avants rasulting in daath) Last

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.
Obesity
Debility

23b. Did tobacco uaa contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy parformed? 1☐ Yas 2☒ No
24b. Wara autopsy findings availabla prior to complation of ceusa of death? 1☐ Yas 2☒ No

25. Was cesa rafarrad to madical examiner? 1☐ Yas 2☒ No
26. Placa of Daath *(Chack only ona)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*
27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined
28a. Data of Injury *(Month, Day Yaar)*
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurrad
28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. *(Specify)*
28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowladga, daath occurrad at tha tima, date and placa, and dua to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, daath occurrad at the time, data and placa, and dua to tha causa(s) and mannar stated.
29b. Signatura and title of certifiar: Steven Fuller for
29c. Licansa number: A36078
29d. Data signad *(Month, Day, Yaar)*: 1-30-01
30. Nama and addrass of parson who complatad causa of daath (Item 23a) (Type, Print): STEVEN Fuller 7600 Carroll Ave., TAKOMA PARK, MD 20912

State Registrar

31. Data filed *(Month, Day, Yaar)*: FEB 01 2001
32. Registrar's Signatura: Donna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04128

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Chappell W. Parton
2. Dete of Deeth — Month: January; Day: 30; Yeer: 2001
3. Time of Death: 6:00pm
4e. Feciility Neme *(If not institution, give street end number)*: 6606 Sunset Drive
4b. City, Town, or Location of Deeth: Eldersburg
4c. County of Deeth: Carroll

Funeral Director

5. Social Security Number: 237 40 3335
6. Sex: ☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 70 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Year)*: Apr 20, 1930
9. Birthplece *(Stete or Foreign Country)*: North Carolina

Usuel Residenca of Decedent

10a. Stete: MD
10b. County: Carroll
10c. City, Town or Location: Eldersburg
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 6606 Sunset Drive
10f. Zip Code: 21784
10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? ☒ Yes 2☐ No If Yes, Give Year or Dates: 1948-68
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16e. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Mechanic
16b. Kind of Business/Industry: Montgomery Wards

17. Father's Name *(First, Middle, Last)*: Sigby Parton
18. Mother's Name *(First, Middle, Maiden Surneme)*: Cumi Rogers

19a. Informent's Name/Relationship *(Type, Print)*: Jasen Parton/Son
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 9030B Stebbing Way Laurel, Maryland 20723

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Metro Crematory — Dete: 2-2-2001
20c. Location - City or Town, State: Catonsville, MD

21. Signature of Funeral Servica Licensee: Thomas Ellis mo1044
22. Name end Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. — Approximete Interval Between Onset end Deeth

Immediete Cause (Final diseese or condition resulting in death): a. metastatic lung cancer — 6 months

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest:
b. Due to (or es e consequence of):
c. Due to (or es e consequence of):
d.

Pert II. **Other eignificant conditione** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cauee of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Plece of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residenca 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end manner stated.

29b. Signature end title of cartifier: Thomas Ellis MD
29c. License number: D19105
29d. Date signed *(Month, Dey, Year)*: 2/1/01

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print): 532 Baltimore BLVD Westminster MD 21157

State Registrar

31. Dete filed *(Month, Day, Yeer)*: FEB 05 2001
32. Registrer's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

(10)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04129

Forrest Russell

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Forest Davis Russell,Sr.
2. Date of Death Month Day Year: January 27 2001
3. Time of Death: 1940
4a. Facility Name *(If not institution, give street and number)*: The Memorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 220-09-8498
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 23,1911
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Dorchester
10c. City, Town or Location: Hurlock
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4312 Russell Road
10f. Zip Code: 21643
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 3 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Foreman
16b. Kind of Business/Industry: Wachsberg Pickle Co.

17. Father's Name *(First, Middle, Last)*: Charles Boggs
18. Mother's Name *(First, Middle, Maiden Surname)*: Maude Russell

19a. Informant's Name/Relationship *(Type, Print)*: Irvin Russell / Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O.Box 391, Hurlock,Maryland 21643

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Pleasant Cemetery
Date: 2/3/2001
20c. Location - City or Town, State: Preston,Maryland

21. Signature of Funeral Service Licensee ▶
22. Name and Address of Facility: Bennie Smith Funeral Home P.O.Box 1687, Easton,Maryland 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Prostatic Carcinoma — 1 YR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Organic Brain Syndrome
Chronic Obstructive Pulmonary Disease
Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier ▶ MD
29c. License number: D35284
29d. Date signed *(Month, Day, Year)*: 1/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andrea M. Allen,M D , 219 S. Washington Street, Easton,Maryland 21601

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 02 2001
32. Registrar's Signature ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04130

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): KATHRYN LOUISE ROTHENHOEFER

2. Deta of Deeth: Month JANUARY Dey 28, Yeer 2001

3. Time of Deeth: 3:05 AM

4e Feciity Neme (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Deeth: Frederick

4c. County of Deeth: Frederick

Funeral Director

5. Social Security Number: 214-42-1014

6. Sex: 1☐ M 2☒ F

7. Aga (In yrs. last birthday): 96 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 20, 1904

9. Birthplece (Stete or Foraign Country): Maryland

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 104 Upper College Terrace

10f. Zip Code: 21701

10g. Citizen of Whet Country?: U.S.A.

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+): 2

16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Neme (First, Middle, Last): Fred Kottmyer

18. Mother's Name (First, Middle, Meiden Surneme): Leona Quyn

19a. Informent's Neme/Reletionship (Type, Print): Mr. Frank W. Rothenhoefer, Jr., Son

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 8135 Claiborne Drive, Frederick, Md. 21702

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Zion Lutheran Cemetery, Feb. 2, 2001

Dete

20c. Location - Clty or Town, Stete: Middletown, Maryland

21. Signeture of Funeral Service Licensee: ▶ Richard E. Traf M00255

22. Name end Address of Feciity: Keeney and Basford PA Funeral Home 106 East Church St., Frederick, Md. 21701

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Finel disease or condition resulting in death) e. Pneumonia — 1w/y

Due to (or as e consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular accident

atrial fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to compiation of causa of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one) Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and piece, end due to the ceuse(s) end manner es steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: ▶ Austin Pearre

29c. License number: D09689

29d. Date signed (Month, Day, Year): 1/31/01

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print): Austin Pearre, M.D., 300 West Ninth Street, Frederick, Maryland 21701

State Registrar

31. Dete filed (Month, Day, Year): JAN 3 1 2001

32. Registrer's Signeture: ▶ Benna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended item#28c per MD FCHD,KS

Certificate of Death

2/05/01

Reg. No. 2001 04131

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Minnie Kessler Stern

2. Date of Death: Month: January Dey: 23 Year: 2001

3. Time of Death: 8:25 PM

4a. Facility Name *(If not institution, give street end number)*: Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 215-20-8260

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 90 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 15, 1910

9. Birthplace *(State or Foreign Country)*: Russia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: Parkview Apts., Carroll Parkway

10f. Zip Code: 21701

10g. Citizen of Whet Country?: U.S.A.

11. Meritel Stetus: 1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever In U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 10 | College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Merchant

16b. Kind of Business/Industry: Retail Sales

17. Fether's Neme *(First, Middle, Last)*: Edward Kessler

18. Mother's Name *(First, Middle, Maiden Surneme)*: Stella Cohen

19a. Informent's Name/Reletionship *(Type, Print)*: Seymour B. Stern/Son

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 20 Fairview Avenue, Frederick, Maryland 21701

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Plece of Disposition *(Neme of cemetery, cremetory or other piece)*: Resthaven Memorial Gardens | Date: Jan. 26, 2001

20c. Location - City or Town, Stete: Frederick, Md.

21. Signature of Funeral Service Licensee: Leland C.C. Basford M00021

22. Neme end Address of Fecility: Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List *only* one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediate Cause (Finel diseese or condition resulting in death) e. Pneumonia — Approximate Interval: 72 hrs

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in deeth) Last

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Deeth *(Check only one)*: Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: ▶ Philip Shapiro, MD

29c. License number: D07186

29d. Date signed *(Month, Dey, Year)*: 1/24/01

30. Neme and address of person who completed cause of death (Item 23a) (Type/Print): Philip Shapiro, M.D., 814 Toll House Avenue, Frederick, Maryland 21701

State Registrar

31. Dete filed *(Month, Dey, Year)*: JAN 25 2001

32. Registrer's Signeture: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04132

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ella Mae Seabolt
2. Date of Death (Month, Day, Year): January 26 2001
3. Time of Death: 2:14 AM
4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 214-30-0272
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 9,1909
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Ijamsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11667 Browningsville Road
10f. Zip Code: 21754
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): James Yeary
18. Mother's Name (First, Middle, Maiden Surname): Amanda Yeary

19a. Informant's Name/Relationship (Type, Print): Robert Seabolt Jr./ Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 24611 Kings Valley Road, Damascus, Md 20872

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Forest Oak Cemetery | Date: 1/30/2001
20c. Location - City or Town, State: Gaithersburg, Maryland

21. Signature of Funeral Service Licensee: Isabel D Wynn
22. Name and Address of Facility: Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disaase or condition resulting in death): e. ASCVD — years.
Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uae contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes en eutopsy performed? 1☐ Yas 2☑ No
24b. Were eutopsy tindings availeble prior to completion of causa of deeth? 1☐ Yas 2☐ No

25. Wes cese referred to medicel examiner? 1☑ Yes 2☐ No
26. Plece of Deeth (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Neturel 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end place, end due to the ceuse(s) end menner as stated. 2☑ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to the ceuse(s) end menner stated.
29b. Signature and title of certifier: Andrew Zarick
29c. License number: D35164
29d. Date signed (Month, Dey, Yeer): January 26, 2001
30. Neme end address of person who completes ceuse of death (Item 23a) (Type, Print): Andrew Zarick M.D. 1080 West Patrick Street, Frederick, Maryland

State Registrar

31. Date filed (Month, Day, Year): JAN 2 9 2001
32. Registrar's Signature: Jenna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04133

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret Mary Smith
2. Data of Death: Month January Day 30 Year 2001
3. Tima of Death: 10:10PM
4a Facility Nama (If not institution, giva street and number): The Garden House at Edenton
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 103-20-6205
6. Sex: 1☐ M 2☒ F
7. Aga (In yrs. last birthday): 78 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Mar. 20, 1922
9. Birthplaca (State or Foreign Country): Indiana

Usual Rasidanca of Decadant

10a. Stata: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 5800 Genesis Lane
10f. Zip Code: 21703
10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decadant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yes, Giva Yaar or Datas:
13. Was Dacedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, Whita, atc. Specify: White

15. Decadent's Education (Specify only highast grada completed): Elamentary/Secondary (0-12): Collega (1-4or 5+): 4
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): secretary
16b. Kind of Business/Industry: Medical Hospital

17. Fathar's Nama (First, Middla, Last): Edward Andrew Keller
18. Mothar's Nama (First, Middla, Maidan Sumama): Margaret Ellen Thompson

19a. Informant's Name/Ralationship (Type, Print): John J. Smith, son
19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 6 Wisner Place, Middletown, New York 10940

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other (Specify)
20b. Placa of Disposition (Name of cematary, cramatory or othar placa): Wallkill Cemetery Data: Feb 5, 2001
20c. Location - City or Town, Stata: Middletown, New York

21. Signatura of Funaral Sarvica Licensee: Ryan M. Bugar M00999
22. Nama and Addrass of Facility: Keeney and Basford Funeral Home 106 East Church Street, Frederick, MD 21701

Physician /Medical Examiner

23a. Part I. Enter the disaasa, or complications that caused tha daath. Do not anter tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona cause on each line.

Approximata Intarval Batwean Onset and Death

Immediata Causa (Final disaasa or condition rasulting in daath):
a. Metastatic Breast Cancer — 1 year
Dua to (or as a consequanca of):

Sequantially list conditions, if any, laading to immadiata causa. Enter Undarlying Cause (Disaasa or Injury that Initiated avants rasulting in daath) Last:
b.
Due to (or es a consequence of):
c.
Due to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to deeth but not rasulting in tha undarlying causa givan in Part I.: Alzheimer's Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Wes casa rafarred to medical examinar? 1☐ Yas 2☒ No
26. Place of Death (Check only ona): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Homa 5☐ Residanca 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)
28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1☒ **Certifying Physician**: To the best of my knowledga, deeth occurrad at tha tima, data and placa, and dua to the causa(s) and mannar as stated. 2☐ **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, death occurrad at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signatura and title of cartifiar
29c. Licansa number: D26516
29d. Data signed (Month, Day, Year): JAN 31 2001

30. Nama and addrass of parson who complatad causa of daath (Item 23a) (Type, Print): ALLEN J GILSON MD 1775 TANEY AVE FREDERICK MD 21702

State Registrar

31. Data filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signatura: Benna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04134

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Bertha Mae Stanley
2. Date of Death Month / Day / Year: January 27, 2001
3. Time of Death: 9:35 pm
4a. Facility Name *(If not institution, give street and number)*: Fort Washington Hospital
4b. City, Town, or Location of Death: Fort Washington
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 297-20-9249
6. Sex: 1☐ M 2☑ F
7. Age *(In yrs. last birthday)*: 78 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: August 3, 1922
9. Birthplace *(State or Foreign Country)*: Ohio

Usual Residence of Decedent

10a. State: MD
10b. County: Dorchester
10c. City, Town or Location: Cambridge
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 725 Greenwood Avenue
10f. Zip Code: 21613
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4 or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Production Worker
16b. Kind of Business/Industry: Seafood Industry

17. Father's Name *(First, Middle, Last)*: Charles Smith
18. Mother's Name *(First, Middle, Maiden Surname)*: Bessie Carter

19a. Informant's Name/Relationship *(Type, Print)*: James Stanley
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 403-Apt.-A Secluded Post Circle-Glen Burnie, MD. 21061

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Eastern Shore Veterans Cemetery — Date: 2/5/2001
20c. Location - City or Town, State: Hurlock, Maryland

21. Signature of Funeral Service Licensee: Janelle C. Henry
22. Name and Address of Facility: Henry Funeral Home P.A. 510 Washington St. Cambridge, Maryland 21613

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Pneumonia	days
Due to (or as a consequence of):	b. Multiple myeloma	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. Renal insufficiency	years
Due to (or as a consequence of):	d. Pancytopenia	days

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rointan Farahi M.D.
29c. License number: D43446
29d. Date signed *(Month, Day, Year)*: 1.28.01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): ROINTAN FARAHI-FAR M.D. 9801 Georgia Ave Suit 3-35 SILVER SPRING, MD 20902

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 31 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

BERTHA STANLEY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04135

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ernest Oscar Testerman

2. Date of Death — Month: January Day: 27 Year: 2001

3. Time of Death: 7:58 p.m.

4a. Facility Name *(If not institution, give street end number)*: Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 233-40-5072

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 73 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 12, 1927

9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Monrovia

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 11920 Mid County Drive

10f. Zip Code: 21770

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 45-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: General Foreman

16b. Kind of Business/Industry: Federal Government

17. Father's Name *(First, Middle, Last)*: James Arthur Testerman, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Leticia Thompson

19a. Informant's Name/Reletionship *(Type, Print)*: Kyra Pare' / daughter

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 10305 Coppermine Court, Union Bridge, MD 21791

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Placa of Disposition *(Neme of cemetery, cremetory or other pleca)*: Resthaven Mem. Gardens — Date: 1/31/01

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Jacqueline L Clark

22. Name end Address of Facility: Stauffer Funeral Homes, P.A. 8 East Ridgeville Blvd., Mt. Airy, MD 21771

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset end Death

Immediete Ceuse (Finel diseese or condition resulting in deeth)

e. Atherosclerotic cardiovascular disease — 5 years

Due to (or es e consequenca of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery bypass, congestive heart failure, prostate cancer, non hodgkins lymphoma

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospitel: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end pleca, end due to the ceuse(s) and menner steted.

29b. Signature and title of certifier: Ali J. Ghorbani MD

29c. License number: D35183

29d. Date signed *(Month, Dey, Year)*: 2/1/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ali J. Ghorbani 300 W 9th St Frederick MD

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 02 2001

32. Registrar's Signature: Donna D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04136

NAME KNOWN TO PHYSICIAN: WOOTERS, ALFRED H.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALFRED HENRY WOOTERS, SR
2. Date of Death Month Day Year: JANUARY 26, 2001
3. Time of Death: 12:01 AM
4a. Facility Name (If not institution, give street and number): VA MARYLAND HEALTHCARE SYSTEM
4b. City, Town, or Location of Death: PERRY POINT
4c. County of Death: CECIL

Funeral Director

5. Social Security Number: 214-28-7861
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 75 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPT. 30, 1925
9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: TALBOT
10c. City, Town or Location: EASTON
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8713 SWANN HAVEN RD
10f. Zip Code: 21601
10g. Citizen of What Country?: USA
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yaa or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grada completed): Elementary/Secondary (0-12): 9; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CARPENTER
16b. Kind of Business/Industry: HOME IMPROVEMENT
17. Father's Name (First, Middle, Last): CLARENCE W. WOOTERS
18. Mother's Name (First, Middle, Maiden Surname): ANITA EBERHARD
19a. Informant's Name/Relationship (Type, Print): BARBARA WOOTERS/WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8713 SWANN HAVEN RD EASTON, MD 21601
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MD VETERANS CEMETERY
Date: 1-31-01
20c. Location - City or Town, State: HURLOCK, MD
21. Signature of Funeral Service Licensee: Joseph M. Ostrusk
22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disaase or condition resulting in death): a. PNEUMONIA — UNKNOWN

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medicel examiner? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one): Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) end manner es stated. 2 [ ] **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D19402
29d. Date signed (Month, Day, Year): JANUARY 26, 2001

30. Nama and address of person who completed ceuse of death (Item 23a) (Type, Print): SUKH DEV S. AUJLA M.D., VA MARYLAND HEALTHCARE SYSTEM, PERRY POINT, MD. 21902

State Registrar

31. Data filed (Month, Day, Year): JAN 29 2001
32. Registrar's Signature: Denise B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04137

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PAUL LEROY WALBRIDGE

2. Date of Death: Month JANUARY Day 31 Year 2001

3. Time of Death: 7:15 PM

4a. Facility Name (If not institution, give street and number): TALBOT HOSPICE HOUSE

4b. City, Town, or Location of Death: EASTON

4c. County of Death: TALBOT

Funeral Director

5. Social Security Number: 213-01-8151

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JANUARY 27, 1913

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: TALBOT

10c. City, Town or Location: TRAPPE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 5073 RIVER LANE

10f. Zip Code: 21673

10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CARPENTER

16b. Kind of Business/Industry: CONSTRUCTION

17. Father's Name (First, Middle, Last): CLARENCE WILLIAM WALBRIDGE

18. Mother's Name (First, Middle, Maiden Surname): FLORENCE M. HUTCHISON

19a. Informant's Name/Relationship (Type, Print): MARIE WALBRIDGE/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5073 RIVER LANE, TRAPPE, MD 21673

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): WOODLAWN MEMORIAL PARK

Date: 2-05-01

20c. Location - City or Town, State: EASTON, MD

21. Signature of Funeral Service Licensee: JOHN R. MERCERON CFSP

22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hepatocellular carcinoma — 18 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice house

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D50804

29d. Date signed (Month, Day, Year): 2-1-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mark Malkus, MD 408 Byrn Street Cambridge, MD 21613

State Registrar

31. Date filed (Month, Day, Year): FEB 08 2001

32. Registrar's Signature: B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04138

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Walter Ivy Warner

2. Date of Death (Month, Day, Year): January 30 2001

3. Time of Death: 8:45 am

4a. Facility Name (If not institution, give street and number): Dorchester General Hospital

4b. City, Town, or Location of Death: Cambridge

4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 214-07-7776

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 92 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 5 1908

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Dorchester

10c. City, Town or Location: Cambridge

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 208 Killarney Road

10f. Zip Code: 21613

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): auditor

16b. Kind of Business/Industry: state income tax div.

17. Father's Name (First, Middle, Last): Wilson Sherman Warner

18. Mother's Name (First, Middle, Maiden Surname): Bessie L. Wroten

19a. Informant's Name/Relationship (Type, Print): Wayne Warner - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 101 High St., Cambridge, MD 21613

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): East New Market cemetery

Date: 2-3

20c. Location - City or Town, State: East New Market, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Thomas Funeral Home, PA
700 Locust St., Cambridge, MD 21613

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

fall

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic heart disease — years

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D

29c. License number: D0056659

29d. Date signed (Month, Day, Year): 1/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MUHAMMAD AFZAL, M.D. 300 AURORA ST, CAMBRIDGE, MD 21613

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001

32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04139

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PATRICIA ANN WYATT

2. Date of Death (Month, Day, Year): January 27, 2001

3. Time of Death: 1650

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 228-56-4968

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 64 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAY 18, 1936

9. Birthplace (State or Foreign Country): WEST VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: WICOMICO

10c. City, Town or Location: SALISBURY

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 604 TRUITT STREET

10f. Zip Code: 21801

10g. Citizen of Whet Country?: USA

11. Meritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Americen Indien, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 10; College (1-4or 5+):

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Neme (First, Middle, Last): SAM BREWSTER

18. Mother's Neme (First, Middle, Maiden Sumeme): ALICE GRAHAM

19a. Informent's Neme/Releflonship (Type, Print): JAMES BOLDEN/SON

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 27617 MT. VERNON ROAD, PRINCESS ANNE, MD 21853

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): SPRINGHILL MEMORY GARDENS

Dete: 1/30/01

20c. Location - City or Town, Stete: HEBRON, MARYLAND

21. Signature of Funeral Service Licensee: Leonard W. Zeller

22. Neme end Address of Fecility: ZELLER FUNERAL HOME, P. O. BOX 3171, 1212 OLD OCEAN CITY ROAD, SALISBURY, MD 21802

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet ceused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in deeth)

a. CONGESTIVE HEART FAILURE

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or Injury ther Initieted events resulting in death) Lest

b. AS END

Due to (or es e consequence of):

c. DM

Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco uee contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveileble prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) and menner es steted. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date end piece, and due to the ceuse(s) end menner steted.

29b. Signature end title of certifier: Dr Chodwicki

29c. License number: 020912

29d. Date signed (Month, Dey, Year): 1-27-01

30. Neme and address of person who completed ceuse of deeth (Item 23a) (Type, Print): DENNIS Chodwicki 400 Eastern Shore Drive Salisbury md 21804

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 31 2001

32. Registrer's Signeture: Jeanne G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

228-56-4968 Balt

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

P. WYATT

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04140

NAME KNOWN TO PHYSICIAN: WONGUS, FRANCIS O. Jr.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Francis Orville Wongus
2. Date of Death — Month: January; Day: 28; Year: 2001
3. Time of Death: 9:05 PM
4a. Facility Name (If not institution, give street and number): VA MARYLAND HEALTHCARE SYSTEM
4b. City, Town, or Location of Death: PERRY POINT
4c. County of Death: CECIL

Funeral Director

5. Social Security Number: 214-42-9134
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 56 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 13, 1944
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Dorchester
10c. City, Town or Location: Cambridge
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 702 Robbins Street
10f. Zip Code: 21613
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No — If Yes, Give Year or Dates: 5/10/62 5/23/72
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Assembly Worker
16b. Kind of Business/Industry: State Hospital
17. Father's Name (First, Middle, Last): Willie Wongus, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Leonia Todd
19a. Informant's Name/Relationship (Type, Print): Rosalee Brannock-Elsey
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 532 Leonards Lane Cambridge, Maryland 21613
20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Eastern Shore Veterans Cemetery
Date: 2/2/2001
20c. Location - City or Town, State: Hurlock, Maryland
21. Signature of Funeral Service Licensee: Janelle C. Henry
22. Name and Address of Facility: Henry Funeral Home P.A. 510 Washington St. Cambridge, Maryland 21613

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. LUNG CANCER — MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D52739
29d. Date signed (Month, Day, Year): January 28 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SURESH SHANDELYA, M.D., VA MARYLAND HEALTHCARE SYSTEM, PERRY POINT, MD 21902

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

AMENDED ITEM# 7 per fh G792 021401 SS

Reg. No. 2001 04141

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

M known as Junius ALLEN

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JUNIUS ALLEN
2. Date of Death: Month FEBRUARY Day 10 Year 2001
3. Time of Death: 04:15
4a. Facility Name (If not Institution, give street and number): Sinai Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-24-9202
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 72 ~~73~~ Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV. 20, 28
9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3910 PICKNEY RD
10f. Zip Code: 21215
10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Detes:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, Whita, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completad): Elementary/Secondary (0-12): 11; Collega (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired): TRUCK DRIVER
16b. Kind of Business/Industry: ARUNDEL CEMENT

17. Fether's Neme (First, Middle, Last): UNKNOWN
18. Mothar's Neme (First, Middle, Maiden Surname): MAZZIE BELL

19a. Informent's Name/Reletionship (Type, Print): EDNA ALLEN, WIFE
19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 3910 PINKNEY RD, BALTO. MD 21215

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): GARRISON FOREST
Data: 2-16-01
20c. Location - City or Town, State: OWING MILLS, MD

21. Signature of Funeral Service Licensee: ▶ Michael Ziglier
22. Name end Address of Facility: HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO, MD 21207

Physician /Medical Examiner

23a. Pert1. Entar tha diseese, or complications that caused tha death. Do not anter tha moda of dying, such es cardiac or raspiratory arrest, shock, or haart failure. List only one ceuse on eech lina.

Approximeta Intarvel Batween Onset end Death

Immediata Causa (Final disease or condition resulting in death)
e. Sepsis
Due to (or as e consequence of):

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
b.
Dua to (or as a consequance of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
SEVERE Congestive heart failure as a result of cardiomyopathy with ejection fraction of 10% and Hypertension, with chronic RENAL failure.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an eutopsy performed? 1☐ Yas 2☑ No
24b. Were eutopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Pleca of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA Othar: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigetion 6☐ Could not be datarmined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To tha best of my knowledge, daeth occurred et tha tima, data and place, and dua to the ceuse(s) end manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred et the time, data end place, and dua to tha cause(s) end mannar stated.

29b. Signature and title of certifier: ▶ BARROCAS, MD
29c. License number: RES 000
29d. Date signed (Month, Day, Year): FEBRUARY 10, 2001

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Alex Barrocas M.D. 2401 West Belvedere Ave Baltimore M.D. 21215

State Registrar

31. Dete filed (Month, Dey, Year): FEB 14 2001
32. Registrer's Signeture: ▶ Benessa D. Sparks

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as tha burial-transit

To Be Completed by Funeral Director

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04142

PATIENT KNOWN AS THELMA ARCHIBALD

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): THELMA ARCHIBALD
2. Date of Death (Month, Day, Year): FEBRUARY 10, 2001
3. Time of Death: 21:00
4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL OF BALTIMORE
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-32-1947
6. Sex: 1☐ M 2☐ F
7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPT. 11, 1932
9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 4021 CEDARDALE RD.
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FOLDER
16b. Kind of Business/Industry: LAUNDRY

17. Father's Name (First, Middle, Last): GEORGE HOLMES
18. Mother's Name (First, Middle, Maiden Surname): ALICE CRAWLEY

19a. Informant's Name/Relationship (Type, Print): LUCILLE STOGDEN-SISTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4021 CEDARDALE RD. BALTO. MD. 21215

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT. ZION CEMETERY | Date: 2/17/01
20c. Location - City or Town, State: LANDSDOWN, MD. 21227

21. Signature of Funeral Service Licensee: LEWIS T. GWYNN — Lewis T. Gwynn
22. Name and Address of Facility: LEWIS T. GWYNN FUNERAL HOME 4517 PARK HEIGHTS AVE. BALTO. MD. 21215-6393

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. PNEUMONIA	ONE WEEK
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: PATRICK BURNETT, M.D.
29c. License number: RES-001
29d. Date signed (Month, Day, Year): FEBRUARY 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PATRICK BURNETT, M.D. SINAI HOSPITAL OF BALTIMORE

State Registrar

31. Date filed (Month, Day, Year): FEB 14 2001
32. Registrar's Signature: Sandra B Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

AMEND ITEM: #23 PART I PER PHY 6/92 2-14-01 WR

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04143

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Data of Death Month Day Year	3. Time of Death
Lennie	Bostic	Jan. 31, 2001	9:30am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1800 North Carey Street	Baltimore	NA

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
249-38-3681A	1☐ M 2☒ F	99 Yrs.			12-25-1901	SC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md	N/A	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1800 North Carey Street	21217	U S A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10th grade	N/A	Cook	unk

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Perkins	Unk

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Effie Cole-Daughter	1800 N. Carey Street Baltimore, Md 21217

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crematory or other piece)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Md National Memorial Park	2-6-01	Laurel, Md

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Dale March	Baltimore, Maryland 21215 WM.C.March FH 4300 Wabash Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. SENILE DEMENTIA CORONARY ARTERY DISEASE

Due to (or as a consequence of):

c. CEREBRAL VASCULAR DISEASE SENILE DEMENTIA.

Due to (or as a consequence of):

d. CEREBRAL VASCULAR DISEASE

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PERIPHERAL VASCULAR DISEASE

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Data signed (Month, Day, Year)
Hayne MD.	D054636	2/2/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SYED HAQUE 201-109 Back River Neck Rd 21221

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signature
FEB 14 2001	Jennie G. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04144

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Merrick Leroy Brooks Jr.

2. Data of Death Month / Day / Year: FEBRUARY 10, 2001

3. Time of Death: 1232 A

4a Facility Name *(If not institution, give street and number)*: Stella Maris Hospice At Mercy

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-12-3516

6. Sex: ☒ 1 M ☐ 2 F

7. Age *(In yrs. last birthday)*: 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Dey, Year)*: Apr. 4, 1921

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residance of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Insida City Limits: ☒ 1 Yas ☐ 2 No

10e. Street and Number: 4502 Springdale Avenue

10f. Zip Coda: 21207

10g. Citizen of Whet Country?: USA

11. Marital Status: ☐ 1 Nevar Married ☐ 2 Married ☒ 3 Widowed ☐ 4 Divorced

12. Was Decedent Evar in U.S. Armed Forcas? ☒ 1 Yas ☐ 2 No. If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) ☐ 1 Yas ☒ 2 No *Specify:*

14. Race - Amarican Indian, Black, Whita, atc. *Specify:* BLACK

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): 12th; Collega (1-4or 5+): 2

16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use retired)*: Letter Carrier

16b. Kind of Businass/Industry: United States Postal Service

17. Fathar's Nama *(First, Middla, Last)*: Merrick L. Brooks Sr.

18. Mothar's Nama *(First, Middla, Maiden Surnama)*: Elizabeth Gray

19a. Informant's Name/Ralationship *(Type, Print)*: Cheryl E. Brooks-daughter

19b. Mailing Addrass *(Street and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda)*: 4502 Springdale Avenue Balto. MD 21207

20a. Mathod of Disposition: ☒ 1 Burial ☐ 2 Cramation ☐ 3 Removal from Stata ☐ 4 Donation ☐ 5 Othar *(Specify)*

20b. Place of Disposition *(Nama of cemafary, cramatory or othar place)*: Arbutus Mem. Park

Data: 02/15

20c. Location - City or Town, Stata: Baltimore, MD

21. Signature of Funaral Service Licensee: Herbert E. Nutter

22. Nama and Addrass of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Balto. MD 21216

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the diseesa, or complications that caused tha daath. Do not anter tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart feilure. List only one causa on aach lina.

Approximata Interval Between Onsat and Daath

Immediata Causa (Final disaasa or condition rasulting in daath)

a. Gangrene Right Foot.

Dua to (or as a consequence of):

Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaase or injury that initiated evants rasulting in death) Last

b. Dua to (or es e consequence of):

c. Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

Prostate Cancer
Multi infarct Dementia
Deabetes Mellatus

23b. Did tobacco use contribute to the cause of death? ☐ 1 Yes ☐ 2 No ☐ 3 Probably ☒ 4 Unknown

24a. Was an autopsy performad? ☐ 1 Yas ☐ 2 No

24b. Wara autopsy findings available prior to complation of causa of death? ☐ 1 Yas ☐ 2 No

25. Wes case rafarred to medical examinar? ☐ 1 Yas ☒ 2 No

26. Place of Deeth *(Check only one)* STELLA MARIS AT MERCY

Hospital: ☐ 1 Inpatiant ☐ 2 ER/Outpatient ☐ 3 DOA

Othar: ☐ 4 Nursing Homa ☐ 5 Rasidance ☒ 6 Othar *(Specify)* HOSPICE

27. Manner of Deeth: ☒ 1 Natural ☐ 2 Accident ☐ 3 Suicida ☐ 4 Homicida ☐ 5 Pending invastigation ☐ 6 Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? ☐ 1 Yes ☐ 2 No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Cartifier *(Check only one)* ☐ 1 **Certifying Physician:** To tha best of my knowledga, daeth occurred at tha time, date and place, and due to tha causa(s) and mannar es stated. ☐ 2 **Medical Examiner:** On tha basis of axamination and/or invastigetion, in my opinion, death occurred et the tima, data and place, and dua to tha cause(s) and mannar stated.

29b. Signatura and tila of cartifiar

29c. Licansa number: D 40854

29d. Data signed *(Month, Day, Year)*: FEBRUARY 12, 2001

30. Nama and addrass of parson who complatad causa of death (Itam 23a) (Type, Print): DAVID RISEBERG, 301 St Paul Pl. BALTIMORE, MD 21202

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Data filed *(Month, Day, Year)*: FEB 14 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEMS# 7&8 per fh G793 031401 SS

Certificate of Death

Reg. No. 2001 04145

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Maggie	T.	Brown	FEB 12 2001	1530

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ST. AGNES HOSPITAL	BALTIMORE	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-20-5598	1☐ M 2☒ F	~~75~~ 74 Yrs.			~~12 22 25~~ 12/22/26	M.D.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4503 Manordene Road	21229	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced XX	1☐ Yes 2☒ No If Yes, Give Year or Dates: XX	1☐ Yes 2☐ No Specify: XX	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8th grade	na	Domestic Engineering	Various Companies

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Louis Brown	Carrie Mason

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rufus Dawson Jr. Grandson	40127 Windmill Circle, Randallstown Md 21133

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) XX	Voshell Memorial Gardens	2/16/01	Baltimore, Md

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Jerome A. Thompson	March F/H West 4300 Wabash Ave, Baltimore, Md 21215

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that ceused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in death)	a. MASSIVE INTRACRANIAL HEMORRHAGE	24 HRS
Due to (or as a consequence of):	b. HYPERTENSION	20 YRS
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or es e consequence of): c.	
	Due to (or es a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of ceuse of deeth?
1☐ Yes 2☑ No	1☐ Yes 2☑ No

25. Was cese referred to medicel examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and place, end due to the cause(s) end menner es steted.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Leila Kump, M.D.	P 14444	FEB 12, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)
LEILA KUMP 900 Caton Ave, Baltimore, MD 21229

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 14 2001	▶ Lenna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME MAGGIE T. BROWN
Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04146

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Pauline Thelma Brown
2. Date of Death: Month 2 Day 11 Year 2001
3. Time of Death: 9:30 p.m.
4a. Facility Name (If not institution, give street and number): Ruxton N.H.
4b. City, Town, or Location of Death: Pikesville
4c. County of Death: NA

Funeral Director

5. Social Security Number: 216-28-7682
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 7-27-1928
9. Birthplace (State or Foreign Country): Md

Usual Residence of Decedent

10a. State: Md
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3808 Derby Manor Drive
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade | College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home Care Provider
16b. Kind of Business/Industry: Day Care
17. Father's Name (First, Middle, Last): Benjamin Allen
18. Mother's Name (First, Middle, Maiden Surname): Mildred Turner
19a. Informant's Name/Relationship (Type, Print): Mildred Gilmore - Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3808 Derby Manor Dr Balto, Md 21215
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Crownsville Veteran | Date: 2-15-01
20c. Location - City or Town, State: Crownsville, Md
21. Signature of Funeral Service Licensee: Teresa A Curtis
22. Name and Address of Facility: March F.H. West 4300 Wabash Ave Balto, Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Ischemic heart Disease

Due to (or as a consequence of):
Chronic Renal failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Severe Peripheral Vascular Disease
Diabetes Mellitus
Previous Strokes

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Edward Klem MD
29c. License number: D19171
29d. Date signed (Month, Day, Year): February 12th, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type/Print): 4000 Old Court Road Pik-Sville, Maryland 21208

State Registrar

31. Date filed (Month, Day, Year): FEB 14 2001
32. Registrar's Signature: Barbara G. Franks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04147

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Edward Brush

2. Data of Death Month / Day / Year: February 11 2001

3. Time of Daath: 5pm

4a. Facility Name *(If not institution, giva street and number)*: 8113 Forest Hill Drive

4b. City, Town, or Location of Daath: Ellicott City

4c. County of Death: Howard

Funeral Director

5. Social Security Numbar: 214 22 1077

6. Sax: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Yaar)*: Jan 20, 1928

9. Birthplaca *(Stata or Foraign Country)*: Maryland

Usual Residance of Dacadent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Insida City Limits: 1☐Yas 2☒No

10e. Street and Numbar: 8113 Forest Hill Drive

10f. Zip Coda: 21043

10g. Citizan of What Country?: United States

11. Maritai Status: 1☐Navar Married 2☐Married 3☒Widowed 4☐Divorced

12. Wes Dacadant Evar in U.S. Armad Forces? 1☒Yas 2☐No If Yes, Give Yaar or Datas: 1946-47

13. Was Decadant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1☐Yas 2☒No *Specify:*

14. Race - American Indian, Bleck, Whita, atc. *Specify:* white

15. Dacadant's Education *(Spacify only highest grada compliatad)*: Elamantary/Secondary (0-12): 8 / Collaga (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT usa ratired)*: Steel Worker

16b. Kind of Business/Industry: Bethlehem Steel

17. Fathar's Name *(First, Middla, Last)*: Stanislaus Brus

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Stella (unknown)

19a. Informant's Name/Relationship *(Typa, Print)*: Edward J. Brush/Son

19b. Mailing Addrass *(Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Code)*: 6310 Stevens Forest Rd. Columbia, MD 21046

20a. Method of Disposition: 1☐Burial 2☒Cramation 3☐Removal from Stata 4☐Donation 5☐Othar *(Specify)*

20b. Place of Disposition *(Nama of cemetary, cramatory or othar placa)*: Metro Crematory

Date: 2-12-2001

20c. Location - City or Town, Stata: Catonsville, MD

21. Signatura of Funaral Sarvica Licensaa: Shawn A Ellis-Witzke MD1044

22. Nama and Addrass of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Entar tha disease, or complications that caused tha daath. Do not enter the moda of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only ona causa on aach line.

Approximata Interval Batwaan Onset and Daath

Immadiata Causa (Final disaasa or condition rasulting in daath)

a. Metastatic lung cancer

Due to (or as a consaquence of):

Sequantially list conditions, if any, leading to immadiata causa. Entar Undarlying Cause (Diseasa or injury that initiated avants rasulting in daath) Last

b.

Due to (or as a consaquance of):

c.

Dua to (or as a consaquance of):

d.

Part II. **Other significant conditions** contributing to daath but not resulting in tha undarlying causa givan in Part I.

23b. Did tobacco usa contributa to tha causa of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Wara autopsy findings availabla prior to completion of cause of death? 1☐Yas 2☐No

25. Was case rafarrad to medical examinar? 1☐Yas 2☒No

26. Placa of Death *(Check only one)*: Hospital: 1☐Inpatiant 2☐ER/Outpatiant 3☐DOA Other: 4☐Nursing Homa 5☒Residence 6☐Othar *(Spacify)*

27. Manner of Death: 1☒Natural 2☐Accidant 3☐Suicida 4☐Homicida 5☐Panding invastigation 6☐Could not ba determinad

28a. Date of Injury *(Month, Day Yaar)*

28b. Tima of Injury

28c. Injury at Work? 1☐Yas 2☐No

28d. Dascribe how injury occurred

28a. Place of Injury - At home, farm, streat, factory, office building, atc. *(Spacify)*

28f. Location *(Street and Numbar or Rural Routa Numbar, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledga, daath occurrad at tha tima, date and placa, and due to the causa(s) and mannar as stated. 2☐ **Madical Examinar:** On tha basis of examination and/or invastigation, in my opinion, daath occurrad at tha time, date and placa, and dua to the causa(s) and manner statad.

29b. Signatura and title of certifier: MD

29c. Licansa number: D013998

29d. Data signad *(Month, Day, Yaar)*: Feb. 12, 2001

30. Nama and addrass of parson who completad causa of daath (Item 23a) (Type, Print): 4801 DORSEY HALL DRIVE, ELLICOTT CITY MD 21042 ALAN G STAHL M.D

State Registrar

31. Data filed *(Month, Day, Yaar)*: FEB 14 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is markad other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04148

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CORA ELLEN BYNUM
2. Data of Death: Month: February Day: 9 Year: 2001
3. Time of Death: 0713
4a. Facility Name (If not institution, give street and number): UNION MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-50-1614
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 55 Yrs. If Under 1 Yaar: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): OCT. 10, 1945
9. Birthplaca (State or Foraign Country): MARYLAND

Usual Rasidance of Decedent

10a. Stata: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Insida City Limits: 1☒ Yas 2☐ No
10e. Street and Number: 5201 FREDCREST ROAD
10f. Zip Coda: 21229
10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Navar Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedant Evar in U.S. Armad Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1☐ Yas 2☒ No Specify:
14. Race - American Indian, Black, Whita, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grada complatad): Elementary/Secondary (0-12): 12TH GRADE; Collega (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): POSTAL CLERK
16b. Kind of Business/Industry: U.S. POST OFFICE

17. Fathar's Nama (First, Middla, Last): NATHANIEL HICKS
18. Mothar's Nama (First, Middla, Maidan Sumama): CORA JONES

19a. Informant's Name/Ralationship (Type, Print): MICHAEL JONES (SON)
19b. Mailing Address (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda): 5201 FREDCREST ROAD, BALTIMORE, MD. 21229

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Nama of cemetery, cremetory or othar placa): DRUID RIDGE CEMETERY. Data: 02-14-01
20c. Location - City or Town, Stata: PIKESVILLE, MARYLAND
21. Signature of Funaral Service Licensee: ▶ [signature]
22. Nama and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217

Physician /Medical Examiner

23a. Part I. Enter tha disaasa, or complications thet caused the daath. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failura. List only ona cause on eech line.

Approximate Interval Between Onsat end Daath

Immediata Causa (Finel disaasa or condition rasulting in daath)
a. Massive Myocardial Infarction — 2 hours
Due to (or as a consequanca of):
b.
Dua to (or as a consequance of):
c.
Dua to (or as a consequanca of):
d.

Sequentially list conditions, if any, leading to immadiate causa. Enter Undarlying Causa (Diseasa or injury that initiated evants rasulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying causa givan in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to complation of causa of death? 1☐ Yas 2☒ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Placa of Daath (Check only ona)
Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA
Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Yaar)
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)
28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledga, daath occurrad at tha tima, date and placa, and due to the causa(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or invastigation, in my opinion, death occurred at the tima, data and place, and dua to tha causa(s) and mannar statad.

29b. Signatura and titla of cartifiar: ▶ Allison N. Williams, MD
29c. Licansa number: AT2438946
29d. Data signed (Month, Day, Year): February 9, 2001

30. Nama and addrass of parson who complatad causa of daath (Item 23a) (Type, Print): Allison N. Williams, MD 201 East University Parkway Union Memorial Hospital Baltimore, Md. 21218

State Registrar

31. Data filed (Month, Day, Year): FEB 14 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 04149

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
JEFFREY P. BOWEN, SR.	Feb 11 2001	1755 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
UNIVERSITY OF MARYLAND	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-70-2085	XX 1 M 2 F	42 Yrs.			March 4, 1958	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	Baltimore City	XX 1 Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1135 Newcomb Way	21205	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 XX Married 3 Widowed 4 Divorced	1 Yes 2 XX No If Yes, Give Year or Dates:	1 Yes XX No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10	0	Cab Driver	Transportation

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charles K. Bowen, SR.	Annie Poe

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Pamela D. Bowen / Wife	1135 Newcomb Way, Baltimore Maryland 21205

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory, or other place)	Date	20c. Location - City or Town, State
XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Gardens of Faith Cemetery	Feb. 15, 2001	Baltimore Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Victor P. Doda, Jr.	Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)	a. SEPSIS	48 hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. CELLULITIS	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CIRRHOSIS

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 X No	1 Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 X No	Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	P10249	Feb 11 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DYLAN STEWART MD UNIVERSITY OF MARYLAND HOSP.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 14 2001	G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Physician/Medical Examiner

01-0799-510
B.K.S
REBECCA BEOWE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM: #17 PER F.H. G792 2-14-01 WR

Certificate of Death

Reg. No. 2001 04150

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Dey Yeer	3. Time of Death
Rebecca Bowe	FEB. 12, 2001	0730 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3915 BATEMAN AVENUE	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Dete of Birth (Month, Day, Year)	9. Birthplece (State or Foreign Country)
219-01-2211	1☐M 2☑F	91 Yrs.			Feb. 10, 1910	N. Carolina

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	Baltimore	1☑Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
3915 Bateman Ave.	21216	USA

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☑Divorced	1☐Yes 2☑No If Yes, Give Year or Dates:	1☐Yes 2☑No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6th		Beautician	Cosmetology

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Jones HENRY PROCTOR	Edna Mullen

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Maria Barnes	3602 Monterey Rd. Apt. F Balto., MD 21218

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, Stete
1☑Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)	Mt. Zion Cemetery	2-16-01	Lansdowne, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	Gary R. March Funeral Home P.A. 2410 Fredhilton Pass Balto., MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximete Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Hypothermia in Association	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. With Alzheimer's Disease	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☑No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 3☐Ectopic pregnency 4☐Pregnant et time of deeth 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertensive and Arteriosclerotic Cardiovascular Disease

23e. Did tobacco use contribute to the cause of death?	24a. Was en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☑Unknown	1☑Yes 2☐No	1☑Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) AT SCENE

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	2/12/01 (Found)	0700 (Found)	1☐Yes 2☑No	Subject Exposed to Cold

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street end Number or Rurel Route Number, City or Town, State)
Lawn	Baltimore, Md.

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner es stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Yeer)
Joseph Pestaner, M.D.	O.C.M.E	FEB. 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Yeer)	32. Registrar's Signature
FEB 14 2001	

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04151

BURNETT, JOHN

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Data of Death Month / Day / Year	3. Time of Death
John	Burnett	FEBRUARY 9 2001	8:20 A.M.

4a Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
FRANKLIN SQUARE HOSPITAL CENTER	ROSEDALE	BALTIMORE

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Yaar: Months / Days	If Undar 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
022-12-8323	1☒M 2☐F	80 Yrs.			July 2,1920	Canada

Usual Rasidence of Decedant

10a. Stete	10b. County	10c. Clty, Town or Location	10d. Insida Clty Limits
Md.	Harford	Abingdon	1☐Yas 2☒No

10e. Street and Number	10f. Zip Coda	10g. Citizen of Whet Country?
3722 Federal Lane	21009	USA

11. Marital Status	12. Was Decedent Evar in U.S. Armed Forcas?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- It Yas, specify Cuban, Maxican, Puarto Rican, atc.)	14. Rece - Amarican Indian, Black, Whita, atc.
1☐Nevar Married 2☐Married 3☒Widowed 4☐Divorced	1☒Yas 2☐No It Yas, Giva Yaar or Datas:	1☐Yas 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highast grada complatad)		16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	Collega (1-4or 5+)		
7 yrs.		Laborer	Steel

17. Fathar's Nama (First, Middla, Last)	18. Mothar's Nema (First, Middla, Maiden Surnema)
Millard Burnett	Theresa Elliott

19a. Intormant's Neme/Ralationship (Type, Print)	19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code)
Barbara Villani Daughter	7615 Gum Rd. Dundalk,Md. 21222

20a. Method ot Disposition	20b. Plece ot Disposition (Neme of camatary, cremetory or othar placa)	Date	20c. Location - City or Town, Stata
1☒Burial 2☐Cramation 3☐Ramoval trom Stata 4☐Donation 5☐Othar (Specify)	Sacred Heart of Mary Cem	Feb 12, 2001	Dundalk,Md.

21. Signature of Funaral Sarvice Licensee	22. Nama and Address of Facility
▶Anthony C. Connelly	Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk,Md. 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart tailura. List only one ceusa on aach lina.

		Approximata Intarval Batween Onsat and Death
Immediate Cause (Final disaasa or condition rasulting in daath)	a. PNEUMONIA	1 DAY
	Due to (or as a consequence ot):	
Sequentially list conditions, if any, laading to immadiate cause. Enter Undarlying Cause (Disease or injury that initiated evants rasulting in death) Last	b.	
	Dua to (or as a consequanca ot):	
	c.	
	Dua to (or as a consequance ot):	
	d.	

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

CONGESTIVE HEART FAILURE

ALZHEIMERS, DEMENTIA

23b. Did **tobacco use contribute to the cause of death?** 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Wara autopsy findings availabla prior to completion of ceusa of death?
1☐Yas 2☒No	1☐Yas 2☐No

25. Was casa raterred to medical examinar?	26. Placa of Daath (Check only ona)	
1☒Yes 2☐No	Hospital: 1☒Inpatiant 2☐ER/Outpatient 3☐DOA	Othar: 4☐Nursing Homa 5☐Rasidance 6☐Othar (Specify)

27. Mannar ot Death	28a. Data ot Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Neturel 2☐Accidant 3☐Suicida 4☐Homicida 5☐Pending invastigation 8☐Could not be datarmined		M	1☐Yas 2☐No	
	28e. Plece of Injury - At homa, tarm, street, tectory, office building, atc. (Specify)			28t. Location (Street end Number or Rural Routa Number, City or Town, Stete)

29a. Cartifiar (Check only one) 1☒ **Certifying Physician:** To tha best ot my knowledga, daath occurred at tha time, data and place, and dua to tha causa(s) and mannar es steted.
2☐ **Medical Examiner:** On tha basis ot axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and dua to tha cause(s) and mannar stated.

29b. Signatura and title of certifiar	29c. Licansa number	29d. Data signad (Month, Day, Year)
▶Marco Zamora, MD	D 40819	FEBRUARY 9, 2001

30. Nama and addrass of person who completed causa of daath (Item 23a) (Type, Print)
MARCO ZAMORA, MD. 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signature
FEB 14 2001	▶Jeanne G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 04152

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PHYLLIS E. BRODERICK
2. Date of Death (Month, Day, Yeer): FEBRUARY 12 2001
3. Time of Death: 6:11A M
4a. Facility Name (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-24-1198
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 71 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Yeer): Jan. 15, 1930
9. Birthplece (State or Foreign Country): Md.

Usuel Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Timonium
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2422 Chetwood Cr. Apt. 202
10f. Zip Code: 21093
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 2
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Medical Assistant
18b. Kind of Business/Industry: Sinai Hospital

17. Father's Name (First, Middle, Last): Claude J. Hanson
18. Mother's Name (First, Middle, Maiden Sumame): Mable Snyder

19a. Informant's Name/Relationship (Type, Print): Mrs. Colleen A. Reynolds/dtr.
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 2000 Challedon Ct. Jarrettsville, Md. 21084

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Gardens of Faith
Dete: 2/15/2001
20c. Location - City or Town, State: Overlea, Md.

21. Signature of Funeral Service Licentee:
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions thet ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death): a. Inferiom myocardial infarction

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Dete of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Severe COPD

23e. Did tobecco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physicien:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.
29c. Licanse number: D52197
29d. Date signed (Month, Day, Yeer): 02-13-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rekha Mutagi GBMC 6701 N. Charles Street, Baltimore MD 21204

State Registrar

31. Date filed (Month, Day, Yeer): FEB 14 2001
32. Registrar's Signature: Geneva B. Sparks

DHMH 17 Rev 1/2001

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Phyllis Broderick

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04153

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary B. Benges

2. Date of Death — Month: February Day: 13 Year: 2001

3. Time of Death: 02:43

4a. Facility Name (If not institution, give street and number): University of Maryland Medical Systems

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-28-6333

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Year — Months: Days: If Under 24 Hrs. — Hours: Min.:

8. Date of Birth (Month, Day, Year): 9/13/1932

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1125 West Hamburg Street

10f. Zip Code: 21230

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 8 yr's College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Jesse B. Grimm

18. Mother's Name (First, Middle, Maiden Surname): Mary B. Spalt

19a. Informant's Name/Relationship (Type, Print): Mrs. Pamela J. Zelaya - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 Pinewall Place Baltimore, MD 21236

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven

Date: 2/16/01

20c. Location - City or Town, State: Glen Burnie, MD

21. Signature of Funeral Service Licensee: Paul L. Hartsock Jr

22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Rd. Baltimore, MD 21214

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or es a consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco usa contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end manner es steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: C. Jones-Burton M.D.

29c. License number: P13383

29d. Date signed (Month, Day, Year): February 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): C. Jones-Burton 22 South Bedeve St. Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 14 2001

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 04154

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death (Month, Day, Year)	3. Time of Death
BENJAMIN	BERKOW	FEBRUARY 11, 2001	7:40 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2429 SYLVALE ROAD	BALTIMORE	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-07-0918	1 XX M 2 ☐ F	88 Yrs.			MAR. 9, 1912	MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	BALTIMORE	1 ☐ Yes 2 XX No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2429 SYLVALE ROAD	21209	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 XX Widowed 4 ☐ Divorced	1 X Yes 2 ☐ No ARMY	1 ☐ Yes 2 X No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		MANAGER	FURNITURE

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
MICHAEL	BERKOW	IDA	ADLER

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
WENDY BERKOW / DAUGHTER	4-B TROLOD COURT - OWINGS MILLS, MD 21117

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	BETH TFILOH CEMETERY	2/13/01	WOODLAWN, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Robert Thomas	SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ASCVD — 9 yr.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b. Due to (or as e consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE: 23b. Wes decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel deeth 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time ot death 5 ☐ Other (specify) 9 ☐ Unknown	23d. Dete ot delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure

23e. Did tobecco use contribute to the cause ot death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24e. Wes en autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 XX Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Dete ot Injury (Month, Day Year)	28b. Time ot Injury	28c. Injury et Work?	28d. Describe how injury occurred
1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify)

28t. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated.

2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Smuel I Berk MD	D16941	2/12/01

30. Name and address of person who completed cause ot death (Item 23a) (Type, Print)

S Benesh 21 Crossroads Dr Owings Mills md 21117

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 14 2001	Jenna D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #17 PER F.H. G792 2-14-01 WR.

Certificate of Death

Reg. No: 2001 04155

FRANCES BROWN, FEBRUARY 8, 2001
Baltimore, Maryland 21215-0036 @ 4:22 AM

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRANCES TRAVERS SINGLETON BROWN
2. Date of Death (Month, Day, Year): February 8, 2001
3. Time of Death: 4:22 AM
4a. Facility Name (If not institution, give street and number): HOSPICE OF BALTIMORE:GILCHRIST CENETER
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore County

Funeral Director

5. Social Security Number: 578-10-9794
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept 14, 1914
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore County
10c. City, Town or Location: Towson
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 615 Chestnut Avenue
10f. Zip Code: 21204
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Claims Clerk
16b. Kind of Business/Industry: Insurance

17. Father's Name (First, Middle, Last): LOUIS WINFIELD SINGLETON
18. Mother's Name (First, Middle, Maiden Surname): Elsie Jean Travers

19a. Informant's Name/Relationship (Type, Print): Anna Louise Brown (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2802 Goodwood Road, Baltimore, Maryland 21214

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Green Mount Cemetery
Date: 2/9/2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Martin D. Lawson
22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
e. oral-pharyngeal dysphagia

Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Secondary to multiple strokes — 3 months

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: W. Anthony Riley, MD
29c. License number: D25205
29d. Date signed (Month, Day, Year): February 8, 2001
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Balto. MD 21204

State Registrar

31. Date filed (Month, Day, Year): FEB 14 2001
32. Registrar's Signature: Donna G Sparks

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04156

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BARBARA COOKE

2. Date of Death: Month 02 Day 11 Year 01

3. Time of Death: 513p

4e. Facility Name (If not institution, give street and number): FUTURE CARE CANTON HARBOR

4b. City, Town, or Location of Death: BALTO

4c. County of Death:

Funeral Director

5. Social Security Number: 181-12-3280

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 24, 1921

9. Birthplace (State or Foreign Country): Pa.

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1928 Maxwell Ave

10f. Zip Code: 21222

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12 yrs.

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Public Relations

16b. Kind of Business/Industry: Social Security Adm.

17. Father's Name (First, Middle, Last): Julius Buckiso

18. Mother's Name (First, Middle, Maiden Surname): Mary Karslak

19a. Informant's Name/Relationship (Type, Print): Constance Petrush Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1908 Monroe Rd. Dundalk, Md. 21222

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory

Date: Feb 13, 2001

20c. Location - City or Town, State: Baltimore City

21. Signature of Funeral Service Licensee: Anthony C. Connelly

22. Name and Address of Facility: Connelly Funeral Home of Dundalk, P.A. 7110 Sollers POint Rd. Dundalk, MD. 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D47945

29d. Date signed (Month, Day, Year): Feb 13 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HARIS ALEEM 9101 FRANKLIN SQUARE DRIVE BALTIMORE MD 21237

State Registrar

31. Date filed (Month, Day, Year): FEB 14 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM# 20b per fh G792 021501 SS

Certificate of Death

Reg. No. 2001 04157

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ralph Dickerson

2. Date of Death: Month February Day 9 Year 2001

3. Time of Death: 1314

4a. Facility Name (If not institution, give street and number): Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: NA

Funeral Director

5. Social Security Number: 217-32-9300

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 63 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 08-06-37

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 501 Dolphin Street

10f. Zip Code: 21217

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th Grade

College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Otis Dickerson

18. Mother's Name (First, Middle, Maiden Surname): Josephine Wardell

19a. Informant's Name/Relationship (Type, Print): LaVerne Griffin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3449 Cottage Avenue Baltimore, Maryland 21215

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cemetery ~~01-16-2001~~ Date: 2-19-01

20c. Location - City or Town, State: Lansdowne, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Refractionary Ventricular fibrillation

Due to (or as a consequence of): b. Metabolic acidosis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Diabetes Mellitus Type II, Liver Insufficiency/Failure, Ileus, Hyperkalemia, Acute Renal Failure

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: P13520

29d. Date signed (Month, Day, Year): 02/09/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): John Adams MD, c/o Maryland General Hospital

State Registrar

31. Date filed (Month, Day, Year): FEB 14 2001

32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

RALPH DICKERSON

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04158

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Janice Marguerite Dawkins
2. Date of Death: Month: Febvary Day: 12 Year: 2001
3. Time of Death: 12:20am
4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-24-0782
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 5, 1926
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 7203 Brookcrest Way Apt T-1
10f. Zip Code: 21208
10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐ Never Married 2☒ Merried 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: BLACK

15. Decedent's Educetion (Specify only highest grade completed): Elementery/Secondery (0-12): 10th; College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Assembly Worker
16b. Kind of Business/Industry: Eastern Products

17. Father's Name (First, Middle, Last): Willie Gray
18. Mother's Neme (First, Middle, Maiden Surneme): Margaret Butler

19a. Informent's Neme/Relationship (Type, Print): William Dawkins-husband
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 7203 Brookcrest Way Apt T-1 Balto. MD 21208

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): St. John's Meth.Ch.
Dete: 02/16
20c. Location - City or Town, Stete: Calvert Co. MD

21. Signature of Funeral Servica Licensee: ▶ Herbert E. Nutter
22. Name end Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Balto. MD 21216

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line. (Approximete Intervel Between Onset end Death)

tmmediate Ceuse (Finel disease or condition resulting in death): e. Cerebrovascular Accident

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last:
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☑ No
24b. Were eutopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☑ No

25. Wes case referred to medicel examiner? 1☐ Yes 2☑ No
26. Place of Deeth (Check only one): Hospitel: 1☑ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Menner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28e. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) and menner es steted. 2☐ **Medical Examiner:** On the besis of exemination end/or investigetion, in my opinion, deeth occurred et the time, date and piece, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ Gladys Julia Vall M.D.
29c. License number: RES-000
29d. Date signed (Month, Dey, Year): February 12, 2001

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print): Sinai Hospital 2401 West Belvedere Avenue Baltimore Maryland 21215

State Registrar

31. Dete filed (Month, Day, Year): FEB 14 2001
32. Registrar's Signeture: ▶ Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Dawkins, Janice

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04159

Amended Item #31 per DVRG 792 2/14/2001 EW

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Day
2. Deta of Death: Month 2 Dey 10 Yaer 2001
3. Time ot Death: 3.50 pm
4e. Facility Neme (If not institution, give street end number): Shock Trauma Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-74-8647
6. Sax: 1☒ M 2☐ F
7. Aga (In yrs. last birthday): 43 Yrs.
If Under 1 Yeer: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): Dec 14, 1957
9. Birthplece (Stete or Foreign Country): Maryland

Usual Residence ot Decedent

10a. Stete: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 2522 Terra Firma Road
10f. Zip Code: 21225
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Merried 3☐ Widowed 4☐ Divorced
12. Was Decedant Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:
13. Wes Decedent ot Hispenic Origin? (Specify Yas or No- It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT use retired): Steamfitter
16b. Kind ot Business/Industry: Local #486 Plummers & Steam fitter

17. Fether's Neme (First, Middle, Last): William Edward Day Sr.
18. Mother's Name (First, Middle, Maiden Surneme): Virginia Spencer

19a. Intorment's Name/Reletionship (Type, Print): William E. Day Jr.-brother
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 5613 Northgreen Rd. Balto. MD 21244

20e. Method ot Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece ot Disposition (Neme of cemetery, cremetory or other piece): Cedar Hill Cemetery
Dete: 02/16
20c. Location - City or Town, Stete: Baltimore, MD

21. Signature of Funeral Service Licensee: Herbert E. Nutter
22. Name and Address ot Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy Balto. MD 21216

Physician /Medical Examiner

23e. Part1. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode ot dying, such es cardiec or respiretory errest, shock, or heert teilure. List only one cause on each line.

Approximete Interval Between Onsat and Death

Immediate Cause (Finel disease or condition resulting in death): e. Pneumonia — 6 weeks

Due to (or as e consequenca ot):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in deeth) Lest

b. Due to (or es e consequence ot):

c. Due to (or es e consequence ot):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Pert I.

23b. Did tobacco uas contributa to the causa of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings availeble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No

26. Plece ot Deeth (Check only one): Hospitel: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Streat and Number or Rurel Routa Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2☐ Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and pleca, end due to the ceuse(s) end manner steted.

29b. Signeture end title of certifier: MD.
29c. Licensa number: Res 000
29d. Date signed (Month, Dey, Year): 2.10.2001

30. Nema and address of person who completed cause of deeth (Item 23a) (Type, Print): Dr. M. Weinmann, Shock Trauma Center, South Greene St. Baltimore.

State Registrar

31. Date filed (Month, Dey, Year): 2.10.2001
32. Registrer's Signeture: FEB 14 2001 Jeanne G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04160

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RAYMOND DESHNER

2. Date of Death Month FEB Day 11 Year 2001

3. Time of Death: 11:50am

4a. Facility Name *(If not institution, give street and number)*: 607 Dorsey Ave.

4b. City, Town, or Location of Death: Essex

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-01-5393

6. Sex: 1☐ M 2☐ F

7. Age *(In yrs. last birthday)*: 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept.1 1918

9. Birthplace *(State or Foreign Country)*: PA

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 607 Dorsey Ave

10f. Zip Code: 21221

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10th | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Inspector

16b. Kind of Business/Industry: General Motors

17. Father's Name *(First, Middle, Last)*: Frederick Deshner

18. Mother's Name *(First, Middle, Maiden Surname)*: Cora McLaughlin

19a. Informant's Name/Relationship *(Type, Print)*: Clara C. Deshner / wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 607 Dorsey Ave. Baltimore MD 21221

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gardens Of Faith | Date: 2/14/01

20c. Location - City or Town, State: Rossville MD

21. Signature of Funeral Service Licensee: R. Terry Connelly

22. Name and Address of Facility: Connelly Funeral Home of Essex, 300 Mace Ave. Baltimore Md. 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PANCREATIC CANCER — 2 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: PHYSICIAN

29c. License number: D53590

29d. Date signed *(Month, Day, Year)*: FEBRUARY 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SYDNEY DY, MD CARNEGIE 285 — JOHNS HOPKINS HOSPITAL 600 NORTH WOLFE STREET BALTIMORE

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 14 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04161

Desarnette, Van

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Van T DeJarnette	February 10 2001	1140 am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Franklin Square Hospital Center	Rosedale	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
226-24-9091	1☒ M 2☐ F	78 Yrs.			Jan. 27 1923	Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Fallston	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2218 Choate Road	21047	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Ricen, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	1yr	SheetMetal Mechanic	USCoast Guard Yard

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Van T. DeJarnette Sr.	Cary Woosley

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Bruce DeJarnette / son	2218 Choate Road Fallston MD 21047

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Oak LAwn Cemetery	2/13/01	Baltimore MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ R. Terry Connelly	Connelly Funeral Home of Essex 300 Mace AVe. Baltimore MD 21221

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Final diseese or condition resulting in deeth)	a. Acute Myocardial Infarction	7 Days
Due to (or as a consequence of):		
Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest	b. Arteriosclerotic Cardiovascular Disease	20 years
Due to (or as a consequence of):		
	c.	
Due to (or es e consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Hypertension

End Stage Renal failere

Rectum Cancer

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an eutopsy performed?	24b. Were eutopsy findings available prior to completion of ceuse of deeth?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was cese referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner es steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D17728	2-10-01

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

DR Ba Yin Oung 9000 franklin Square Drive Baltimore Maryland 21237

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 14 2001	▶ Deanna D. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, paga 2 should be detached for use as tha burial-transit

To Be Completed by Funeral Director

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04162

RUTH DANIELS

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ruth Daniels
2. Date of Death — Month: February; Day: 10; Year: 2001
3. Time of Death: 0300 AM
4a. Facility Name *(If not institution, give street and number)*: 2043 WHEELER AVENUE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 034-28-4636
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 73 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MAY 26, 1927
9. Birthplace *(State or Foreign Country)*: WEST VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2043 WHEELER AVENUE
10f. Zip Code: 21216
10g. Citizen of What Country?: USA.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): ; College (1-4or 5+): B.A. DEGREE
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: FRANK R. SAUNDERS
18. Mother's Name *(First, Middle, Maiden Surname)*: VERA E. GROVE

19a. Informant's Name/Relationship *(Type, Print)*: GROVER DUBOSE (COUSIN)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 70 WATERS EDGE RYE, NY 10580

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: ARBUTUS CEMETERY — Date: 02-17-01
20c. Location - City or Town, State: ARBUTUS, MARYLAND

21. Signature of Funeral Service Licensee: Robert A. Wells
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic Hypertensive Cardiovascular Disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Craig Gold DO
29c. License number: H 53088
29d. Date signed *(Month, Day, Year)*: February 13, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Craig Gold DO 222 West Coldspring Lane Baltimore, Maryland 21210

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 14 2001
32. Registrar's Signature: Geneva S. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04163

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth Davis
2. Date of Death (Month, Day, Year): February 12, 2001
3. Time of Death: 10:40 AM
4a. Facility Name (If not institution, give street and number): 434 Oxford Ct.
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-20-6290
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 7, 1927
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 434 Oxford Ct.
10f. Zip Code: 21201
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th; College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Baker
16b. Kind of Business/Industry: Bakery
17. Father's Name (First, Middle, Last): Henry Holmes
18. Mother's Name (First, Middle, Maiden Surname): Mildred Muse
19a. Informant's Name/Relationship (Type, Print): Brenda Corbett - daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 609 George St. Balto., MD. 21201
20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☑ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MD. Nat. Mem. Park
Date: 2-17-01
20c. Location - City or Town, State: Laurel, MD.
21. Signature of Funeral Service Licensee: Gary P. March
22. Name and Address of Facility: Gary P. March Funeral Home P.A. 270 Frechilton Pass Balto., MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. METASTATIC CARCINOMA BREAST — DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Surjit Julka MD
29c. License number: D26395
29d. Date signed (Month, Day, Year): 2/13/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SURJIT S JULKA M.D. 821 N. EUTAW ST. BALTIMORE MD 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 14 2001
32. Registrar's Signature: Geneva B. Lyons

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 04164

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Hazel D. Desautels	February 12, 2001	3:10AM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Futurecare Canton Harbor	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-03-1696	1☐M 2☒F	91 Yrs.			Dec. 8, 1909	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4709 Glenarm Avenue	21206	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
7		Cashier	Dept. Store

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
John W. Reese	Elsa McDaniel

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Lynda Prkna- Granddaughter	8600 Oak Road Baltimore, Maryland 21219

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)	Baltimore National	2/16/01	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Heather Cain	Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CORONARY ARTERY DISEASE — 6 YR

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
DEMENTIA

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as steted. 2☐**Medicel Examinar:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
MD	D47945	Feb 13 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
HARU ALEEM 9101 FRANKLIN SQUARE DRIVE BALTIMORE MD 21237

State Registrar

31. Date filed (Month, Day, Yeer)	32. Registrar's Signature
FEB 14 2001	

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Please Type or Print In Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04165

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ETTA B. EMGE

2. Data of Death (Month, Day, Yaar): February 12, 2001

3. Time of Death: 6:50 pm

4a Facility Nama (If not institution, give street and number): Mariner Health of Glen Burnie

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 213-20-9193

6. Sex: 1☐ M 2☒ F

7. Aga (In yrs. last birthday): 91 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): AUG. 17, 1909

9. Birthplace (State or Foraign Country): MARYLAND

Usual Rasidanca of Decedent

10a. Stata: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: GLEN BURNIE

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 1119 ARMISTEAD ST.

10f. Zip Code: 21061

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorcad

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Race - Amarican Indian, Black, Whita, atc. Specify: WHITE

15. Decedent's Education (Specify only highest grada complatad): Elamantary/Secondary (0-12): 8; Collega (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratirad): HOMEOWNER

16b. Kind of Businass/Industry: OWN HOME

17. Father's Nema (First, Middla, Last): EDWARD FERRIS GRIFFITH

18. Mothar's Nama (First, Middle, Maiden Surnama): ANNE BLANCHE CHANEY

19a. Informant's Name/Ralationship (Type, Print): ETHEL M. DAVIDSON/DAUGHTER

19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1119 ARMISTEAD ST., GLEN BURNIE, MD 21061

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramovel from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cametary, cramatory or othar place): GLEN HAVEN MEM. PK.

Data: FEB. 15 2001

20c. Location - City or Town, State: GLEN BURNIE, MARYLAND

21. Signature of Funaral Sarvica Licensea: [signature]

22. Nama and Address of Facility: KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Etta Enge

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Entar tha diseesa, or complications thet caused the daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on aach line.

Approximate Intervel Between Onset and Death

Immadiata Cause (Final disaasa or condition resulting in death)

a. Alzheimer's Dementia — Due to (or es e consequance of): — years

Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Disease or injury that initiated evants resulting in death) Lest

b. — Dua to (or es a consequance of):

c. — Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.: Congestive heart failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Ware autopsy findings available prior to completion of cause of daath? 1☐ Yes 2☐ No

25. Was casa rafarrad to medical exeminar? 1☐ Yas 2☒ No

26. Placa of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Homa 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Data of Injury (Month, Day Year)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledge, daath occurred at tha tima, data and place, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, death occurred at tha time, data and placa, and dua to tha cause(s) and mannar stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D-40521

29d. Data signed (Month, Day, Year): February 14, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): DR. MAHESH S. OCHANEY, 325 Hospital Drive Suite 103, Glen Burnie MD 21061

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Data filed (Month, Day, Year): FEB 14 2001

32. Registrar's Signature: [signature] Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

01-0724-510
cm
Maurice Antonio Eaton

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04166

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Maurice A. Eaton	February 09, 2001	12:39 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
University of Maryland Medical Center	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-84-6334	1☑M 2☐F	31 Yrs.			Aug. 26, 1969	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Randallstown	1☐Yes 2☑No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3509 Foxcliff Ct. Apt. T2	21133	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Black, White, etc.
1☑Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☑No If Yes, Give Year or Dates:	1☐Yes 2☑No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9th		Packer	Agency

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Jenkins	Brenda Eaton

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Brenda Eaton - mother	6131 Bessemer Ave. Balto., MD 21224

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Mt. Zion Cemetery	2-16-01	Lansdowne, MD.

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: Gary E. Harris Funeral Home P.A. 2410 Frederick Pass Balto., MD. 21229

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Multiple gunshot wounds	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☐Suicide 4☒Homicide 5☐Pending investigation 6☐Could not be determined	2-8-2001	2205 M	1☐Yes 2☒No	Subject was shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Street	1600 Block Druid Hill Baltimore City, Maryland

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Stephen S. Radentz, M.D.	O.C.M.E.	February 09, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 14 2001	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04167

Robert Engle
Baltimore, Maryland 21215-0036

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERT COLEMAN ENGLE
2. Date of Death: Month Feb, Dey 10, Year 2001
3. Time of Death: 1150 AM
4a. Facility Name (If not institution, give street and number): The Memorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 217-22-0057
6. Sex: XX 1 M 2 F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months, Deys | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): November 16, 1927
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Talbot
10c. City, Town or Location: Easton
10d. Inside City Limits: 1 Yes 2 XX No
10e. Street and Number: 602 Hazelwood Drive
10f. Zip Code: 21601
10g. Citizen of What Country?: USA

11. Marital Status: 1 Never Married XX 2 Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 No WWII If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Yes XX No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 8; College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Mechanic
16b. Kind of Business/Industry: Concrete

17. Father's Neme (First, Middle, Last): Henry Scarff Engle
18. Mother's Name (First, Middle, Maiden Surneme): Annie Laura Beamer

19a. Informent's Name/Reletionship (Type, Print): Joan Keller Engle Wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 602 Hazelwood Drive Easton Maryland 21601

20a. Method of Disposition: 1 Buriel 2 XX Cremetion 3 Removel from State 4 Donetion 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Greenmount Cemetery
Dete: 2/13/01
20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Dennis Stephen Kenake
22. Name and Address of Fecility: Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

		Approximete Intervel Between Onset end Death
Immediate Cause (Final diseese or condition resulting in deeth) a.	Renal failure	36 hrs
Due to (or es a consequenca of): b.	metastatic prostate cancer	11 days
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Lest — Due to (or es e consequence of): c.	bone marrow failure c thrombocytopenia	11 days
Due to (or es e consequence of): d.		

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco uee contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Wes en autopsy performed? 1 Yes 2 X No
24b. Were autopsy findings eveilable prior to completion of cause of death? 1 Yes 2 No

25. Wes case referred to medicet examiner? 1 Yes 2 X No

26. Ptece of Death (Check only one): Hospitel: 1 X Inpetient 2 ER/Outpetient 3 DOA; Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Menner of Death: 1 X Neturel 2 Accident 3 Suicide 4 Homicide 5 Pending investigetion 6 Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Ptece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end ptece, end due to the ceuse(s) end manner as stated. 2 Medicel Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end ptece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: Nancy 2. Snow DO
29c. License number: H0053369
29d. Date signed (Month, Day, Year): 2/10/01

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print): Nancy Snow DO 219 South Washington Street Easton Maryland 21601

State Registrar

31. Dete filed (Month, Day, Year): FEB 14 2001
32. Registrer's Signature: Sheena G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 04168

finnerty, Madeline

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Madeline Elizabeth Finnerty	FEBRUARY 9 2001	12:27 pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
GREATER BALTIMORE MEDICAL CENTER	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-30-4567	1☐M 2☒F	68 Yrs.			Jan. 29, 1933	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Dundalk	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1636 Gray Haven Court	21222	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11 Years		Cafeteria Worker	Baltimore County

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Thomas H. Koerner	Theresa Stock

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Husband Mrs. Jerome M. Finnerty	1636 Gray Haven Ct. Dundalk, Maryland 21222

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Sacred Ht. of Jesus	2/13/2001	Dundalk, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiec or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. PNEUMONIA	2 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	b. Due to (or as e consequence of): LUNG CANCER	1 yr.
	c. Due to (or es a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

23e. Did tobecco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted. 2☐**Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	D27730	2/11/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
GARY COHEN, MD 6769 N. CHARLES ST. BALTIMORE, MD 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 14 2001	[signature]

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04169

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth Flaig
2. Date of Death Month: 2 Day: 12 Year: 01
3. Time of Death: 715pm
4a. Facility Name (If not institution, give street and number): Meridian Multi Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-56-3001
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar. 5, 1908
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Timonium
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11 Bailiffs Ct. #302
10f. Zip Code: 21093
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use ratired): Home maker
16b. Kind of Businass/Industry: Own home

17. Father's Name (First, Middle, Last): Joseph J. Amrhein
18. Mother's Name (First, Middle, Maiden Surname): Carolina M. Wolfe

19a. Informant's Name/Relationship (Type, Print): Mr. James Amrhein/brother
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 11 Bailiffs Ct. Timonium, Md. 21093

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Ptece of Disposition (Name of cemetary, cremetory or other place): Baltimore National | Dete: 2/16/01
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused tha death. Do not entar the mode of dying, such as cardiac or raspiratory arrest, shock, or heart feilure. List only one cause on eech tine.

Approximete Intervel Between Onsat and Death

Immediate Cause (Final disease or condition resulting in death): a. Failure to Thrive — weeks

Due to (or es a consequence of): b. Senile Dementia — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or es e consequence of): c.

Due to (or as e consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypothyroidism
Atrial fibrillation

23b. Did 1obacco use contribute 1o the cause of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of daath? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Placa of Deeth (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D17118
29d. Date signed (Month, Dey, Year): Feb 13, 2001

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): Paul Schwartz MD 7700 York Rd 21204

State Registrar

31. Date filed (Month, Day, Year): FEB 14 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 04170

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Walter Fraczkowski
2. Date of Death (Month, Day, Year): February 9, 2001
3. Time of Death: 4:07 AM
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-22-4877
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 6-27-1928
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Rosedale
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 1828 Weyburn Road
10f. Zip Code: 21237
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machinist
16b. Kind of Business/Industry: Western Electric

17. Father's Name (First, Middle, Last): Boleslaw Fraczkowski
18. Mother's Name (First, Middle, Maiden Surname): Salomena Jakubowski

19a. Informent's Name/Reletionship (Type, Print): Teresa Fraczkowski/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1828 Weyburn Road Baltimore MD 21237

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sacred Heart of Jesus | Date: 2/13/01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Cvach/Rosedale Funeral Home 1211 Chesaco Avenue Baltimore MD 21237

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line. | Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac Arrhythemia
Due to (or as e consequence of):
b. Arteriasclerotic Cardiovascular Disease

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Lest
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Wes an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) and menner es steted. 2 ☑ **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) end manner steted.

29b. Signeture and title of certifier: Charles F. O'Donnell MD
29c. License number: D-09383
29d. Date signed (Month, Dey, Year): February 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles F. O'Donnell MD 111 Hamlet Hill Rd Baltimore Md 21210

State Registrar

31. Date filed (Month, Day, Year): FEB 14 2001
32. Registrar's Signature: Geneva B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

01-0762-005
jhm
AZIA DENAE
GRAY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 04171

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Yeer	3. Time of Death
Azia D. Gray	FEBRUARY 09, 2001	22:41 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
FRANKLIN SQUARE HOSPITAL	ESSEX	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Dete of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
227-77-0038	1☐M 2☒F	4 Yrs.			10-09-96	VA

Usuel Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4023 Ardley Avenue	21213	USA

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indien, Black, Whlte, etc.
X 1☐Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates: X	1☐Yes 2☒No X Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
Child	Child	Child	Child

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Surname)
Lamont Gray	Joy Riddick

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213
Cynthia Miller	4023 Ardley Avenue Baltimore, Maryland

20e. Method of Disposition	20b. Place of Disposition (Neme of cemetery, cremetory or other place)	Date	20c. Location - City or Town, Stete
1☒Buriel 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)	Garrison Forest VA Cem.	02-15-01	MD. Owings Mills,

21. Signature of Funeral Service Licensee ▶ Francis J. Stevens

22. Neme end Address of Facility Baltimore, Maryland 21202
WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in deeth)
a. DROWNING

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last
b. Due to (or as e consequence of):
c. Due to (or as e consequence of):
d. Due to (or as e consequence of):

IF FEMALE: 23b. Was decedent pregnent in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnent et time of deeth 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month Day Year

Part II. Other significant conditions contnibuting to death but not resulting in the underlying cause given in Part I.
ASTHMA

23e. Did tobacco use contnibute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24e. Was en autopsy performed? 1☒Yes 2☐No	24b. Were eutopsy findings available prior to completion of cause of deeth? 1☒Yes 2☐No

25. Was case relerred to medical examiner? X 1☒Yes 2☐No

28. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Menner of Death: 1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
2/9/01	2133 M	1☐Yes 2☒No	SUBJECT DROWNED

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
SWIMMING POOL ESSEX COMMUNITY COLLEGE

28f. Location (Street end Number or Rurel Route Number, City or Town, State) 7201 ROSSVILLE BLVD, ESSEX, MD

29a. Certifier (Check only one) 1☐ Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end manner es stated.
2☒ Medical Exeminer: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
▶ [signature]	OCME	FEBRUARY 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARLY G. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Yeer)	32. Registrar's Signature
FEB 14 2001	▶ [signature]

DHMH 17 Rev 1/2001

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Menial Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04172

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROSEALEE K GREEN

2. Date of Death (Month, Day, Year): February 11 2001

3. Time of Death: 7:30 AM

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 225-24-0416

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 20 1927

9. Birthplace (State or Foreign Country): West Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Middle River

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4 SElfridge Road

10f. Zip Code: 21220

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Amaricen Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 4th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): Phillips

18. Mother's Name (First, Middle, Maiden Surnama): Pearl

19a. Informant's Name/Relationship (Type, Print): John Smelser / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4 Selfridge Road Baltimore MD 21220

20a. Method of Disposition: 1☐ Burial 2☒ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Bayview CRematory Inc.

Date: 2/12/01

20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: R. Terry Connelly

22. Name and Address of Facility: Connelly Funeral Home of Essex 300 Mace Ave. Baltimore MD. 21221

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)

a. MYOCARDIAL Infarction

Due to (or as a consequence of):

b. SePSiS

Sequentially list conditions, if any, leading to immediate ceusa. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying ceusa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Death (Check only one) Hospitel: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Neturel 2☐ Accidant 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: 192690

29d. Date signed (Month, Dey, Year): 2/11/01

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): DennisOdie MD 9000 Franklin Square Drive Baltimore, Maryland 21237

State Registrar

31. Date filed (Month, Dey, Year): FEB 14 2001

32. Registrar's Signature: Geneva G. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Green, Rosealee

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04173

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gloria May Gubert
2. Date of Death (Month, Dey, Yeer): FEBRUARY 12, 2001
3. Time of Death: 2:50 AM
4e. Facility Neme (If not institution, give street end number): Stella Maris Hospice at Mercy Hospital
4b. City, Town, or Location of Deeth: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-80-6557
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. lest birthday): 35 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Year): January 9, 1966
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedant

10e. Stete: MD
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☒ Yas 2☐ No
10e. Street end Number: 1309 Clarkson Street
10f. Zip Code: 21230
10g. Citizen of Whet Country?: United States
11. Maritel Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Amarican Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grede completed): Elementery/Secondery (0-12): 7 | College (1-4or 5+): 0
16a. Decedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired): Factory Worker
16b. Kind of Business/Industry: Manufacturing
17. Fether's Name (First, Middle, Last): Harry W. Gubert
18. Mothar's Nama (First, Middla, Maidan Surneme): Margaret A. Lafferty
19e. Informent's Name/Ralationship (Type, Print): Margaret A. Donnelly / Mother
19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 1309 Clarkson Street, Baltimore Maryland 21230
20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetary, crametory or othar placa): Bayview Crematory | Deta: February 14, 2001
20c. Location - City or Town, Stata: Baltimore Maryland
21. Signature of Funerel Service Licensee: ▶ Victor P. Doda, Jr.
22. Neme end Address of Fecility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complicetions that caused tha deeth. Do not enter the mode of dying, such es cerdiac or respiratory arrast, shock, or heart failure. List only one cause on aech lina. — Approximate Intarval Batween Onset end Death

Immediate Ceuse (Finel disease or condition rasulting in deeth)
a. Acquired Immune Deficiency Syndrome
Dua to (or es e consequence of):

Sequantially list conditions, if eny, leeding to immadiate cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Last
b.
Due to (or es e consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yee 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en eutopsy parformad? 1☐ Yas 2☒ No
24b. Were eutopsy findings availabla prior to completion of cause of daeth? 1☐ Yes 2☐ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☒ No
26. Placa of Daath (Chack only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) STELLA MARIS AT MERCY HOSPICE
27. Menner of Death: 1☐ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigetion 6☐ Could not be determined
28e. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stata)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledga, daath occurred at the time, date end piece, end due to tha ceuse(s) end menner as statad.
2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, daath occurred et tha time, data end pleca, end dua to the cause(s) end mannar stetad.

29b. Signature end title of certifier: ▶ MD
29c. License number: D40854
29d. Date signed (Month, Dey, Year): FEBRUARY 12, 2001

30. Neme end address of person who completed ceuse of deeth (Item 23e) (Type, Print): DAVID RISEBERG 301 St Paul Pl BALTIMORE, MD 21202

State Registrar

31. Dete filed (Month, Dey, Year): FEB 14 2001
32. Registrer's Signetura: ▶ B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the deeth certificate be executed within 24 hours after deeth.
To the Funeral Director: After this certificate has been signed by the attanding physician and completely filled in by the funeral director, page 2 should be datached for use as the burial-transit pe

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #7,8 PER F.H. G792 2-16-01 WR. *Certificate of Death* Reg. No: 2001 04174

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Stephanie Gasque
2. Date of Death: Month February Day 12 Year 2001
3. Time of Death: 10:30AM
4a. Facility Name (If not institution, give street and number): 140 N. Hilton St.
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-86-9362
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 33 ~~32~~ Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 30, 1968 ~~1967~~
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 140 N. Hilton St.
10f. Zip Code: 21229
10g. Citizen of What Country? USA

11. Meritel Status: 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - Amarican Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Postal Carrier
16b. Kind of Business/Industry: Post Office

17. Father's Neme (First, Middle, Last): Joseph E. Gasque
18. Mother's Name (First, Middle, Maiden Sumema): Charlie Mae Peay

19a. Informant's Name/Helatiogship (Type, Print): Charlie Mae Gasque- mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 140 N. Hilton St. Balto, MD. 21229

20e. Method of Disposition: 1☑ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of camatary, crematory or othar place): King Memorial Park
Dete: 2-15-01
20c. Location - City or Town, State: Randallstown, MD.

21. Signature of Funeral Service Licensee: Gary F. March
22. Name and Address of Facility: Gary F. March Funeral Home P.A. 270 Fredhilton Pass Balto., MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complicetions that caused the deth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line. Approximete Intervel Between Onset end Death

Immediate Ceuse (Finel diseese or condition resulting in deeth): e. Metastatic Carcinoma of the Breast
Due to (or as a consequence of):

Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest
b.
Due to (or es a consequence of):
c.
Due to (or es e consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No
24b. Were eutopsy findings available prior to completion of ceuse of deeth? 1☐ Yes 2☑ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No
26. Piece of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Menner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28e. Dete of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Steta)

29e. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end manner es stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and pleca, end due to the cause(s) and manner stated.

29b. Signeture and title of certifier: Kathleen Chaconas
29c. License number: D36146
29d. Date signed (Month, Dey, Year): 2/13/2001

30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print): KATHERINE TKACZUK, Univ of MD, 225 Greene St, Baltimore MD 21201

State Registrar

31. Dete filed (Month, Day, Year): FEB 14 2001
32. Registrar's Signeture: Debra B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 04175

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Irene M Grynkiewicz	February	12	2001	1:20 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Johns Hopkins Bayview Hospital	Baltimore	Baltimore City

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-26-5214	1☐M 2☒F	68 Yrs.			March 3 1932	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore City	Dundalk	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6715 Roberts Ave	21224	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12 yrs.		Librarian	School

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Martin Swieczkowski	Mary Kosek

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
John Grynkiewicz Husband	6715 Roberts Ave, Baltimore, Md. 21224

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Sacred Heart of Jesus	Feb. 15, 2001	Dundalk, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Anthony C. Connelly	Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, Md. 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute respiratory distress syndrome	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Sepsis	
	Due to (or as a consequence of):	
	c. pancreatic cancer	
	Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ E M Cole	AJ4147357P7220	February 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
4940 Eastern Ave. Baltimore, MD 21224

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 14 2001	▶ Louis B. Goodall

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 04176

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles Edward Guy
2. Data of Death Month Day Year: February 9, 2001
3. Time of Death: 12:50 AM
4a. Facility Name (If not institution, give street and number): Gilchrist Center for Hospice Care
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore Co.

Funeral Director

5. Social Security Number: 215-28-4000
6. Sex: 1☒ M 2☐ F
7. Age (in yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): May 17, 1932
9. Birthplace (State or Foreign Country): Tennessee

Usual Residance of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Insida City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 1961 Ormand Road
10f. Zip Code: 21222
10g. Citizan of What Country?: United States

11. Marital Status: 1☐ Navar Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedant Evar in U.S. Armed Forcas? 1☒ Yas 2☐ No. If Yas, Giva Yaar or Datas: Korean
13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:
14. Race - Amarican Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highast grada complated): Elementary/Secondary (0-12): 10 Years; Collega (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired): Rail Road Conductor
16b. Kind of Businass/Industry: Rail Road

17. Fathar's Nama (First, Middla, Last): Earnest Guy
18. Mothar's Nama (First, Middla, Maiden Surnama): Edith Hale

19a. Informant's Name/Ralationship (Type, Print): Mrs. Loretta K. Guy (Wife)
19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code): 1961 Ormand Road Dundalk, Maryland 21222

20a. Mathod of Disposition: 1☐ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☒ Othar (Specify) Entombment
20b. Placa of Disposition (Nama of camatary, crematory or othar placa): Gardens of Faith Cem.
Data: 2/14/2001
20c. Location - City or Town, Stata: Baltimore, Maryland

21. Signature of Funaral Service Licensa: Charles W Fritz
22. Nama and Addrass of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part1. Entar tha disaase, or complications that caused tha death. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only one cause on eech line.

Approximata Interval Between Onset and Death

Immediata Causa (Final disaasa or condition rasulting in deeth)
e. lung cancer — years
Dua to (or as a consequanca of):

Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Diseese or injury that initiated events rasulting in death) Last
b. Dua to (or as a consequanca of):
c. Dua to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Were eutopsy findings availabla prior to complation of causa of daath? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical axaminar? 1☐ Yas 2☒ No

26. Placa of Death (Check only one)
Hospital: 1☐ Inpetient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residanca 6☒ Othar (Specify) Hospice

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be determined
28a. Data of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)
28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Certifiar (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledga, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.
2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurred at the tima, data and placa, and dua to tha cause(s) and mannar stated.

29b. Signatura and title of certifiar: Helen M Gardner
29c. License number: D0051926
29d. Data signad (Month, Day, Year): Feb 12, 2001

30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print): Helen M Gardner MD 6565 N. Charles St Baltimore MD 21204

State Registrar

31. Data filed (Month, Day, Year): FEB 14 2001
32. Registrar's Signature: Penny B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural"; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

2/9/01 12:50

Charles Guy

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04177

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BEN BENJAMIN GALLOWAY
2. Date of Death (Month, Day, Year): FEBRUARY 8, 2001
3. Time of Death: 10:39PM
4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-80-8884
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 38 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 1/7/63
9. Birthplace (State or Foreign Country): Baltimore, Md.

Usual Residence of Decedent

10a. State: Md.
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2255 Sidney Ave.
10f. Zip Code: 21230
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Security Guard
16b. Kind of Business/Industry: Security Co.

17. Father's Name (First, Middle, Last): Ben Galloway
18. Mother's Name (First, Middle, Maiden Surname): Dorothy Palmer

19a. Informant's Name/Relationship (Type, Print): Dorothy Palmer Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2255 Sidney Ave, Baltimore, Md. 21230

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cemetery
Date: 2/15/01
20c. Location - City or Town, State: Lansdrown, Md.

21. Signature of Funeral Service Licensee: Floyd M. Estep
22. Name and Address of Facility: Estep Bros Funeral Ser, P.A. 1300 Eutaw Place, Baltimore, Md. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	HIV DISEASE - END STAGE	1 YEAR
Due to (or as a consequence of): b.	ANOXIC ENCEPHALOPATHY	6 MONTHS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	END STAGE RENAL DISEASE	6 MONTHS
Due to (or as a consequence of): d.	DIABETES MELLITUS	10 YEARS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

SEIZURE DISORDER

CARDIOMYOPATHY

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rishi Sawhney
29c. License number: RES-000
29d. Date signed (Month, Day, Year): FEBRUARY 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RISHI SAWHNEY HARBOR HOSPITAL CENTER, 3001 S. HANOVER ST. BALTIMORE, MD 21225

State Registrar

31. Date filed (Month, Day, Year): FEB 14 2001
32. Registrar's Signature: Jeanne G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ADH
MARY JANE HAWKES
01-0796-027

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 04178

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Mary Jane Hawkes	FEBRUARY 11, 2001	1615 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
4360 WILD FILLY COURT	ELLICOTT CITY	HOWARD

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
529 54 2247	1☐M 2☒F	59 Yrs.			Aug 6, 1941	Utah

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Howard	Ellicott City	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4360 Wild Filly Court	21042	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5	Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Daniel H. Davidson	Mary Jansen

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Glenn L. Hawkes/Husband	4360 Wild Filly Court Ellicott City, MD 21042

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☒Removal from State 4☐Donation 5☐Other (Specify)	Bountiful City Cemet.	2-17-2001	Bountiful, Utah

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Shenda Collins-Witzke no1044	Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Multiple Blunt and Sharp

Due to (or as a consequence of):
b. Force Injuries

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

Due to (or as e consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23e. Did tobecco use contribute to the ceuse of death? 1☐Yes 2☑No 3☐Probebly 4☐Unknown	
24e. Was an autopsy performed? 1☒Yes 2☐No	24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No	26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) AT SCENE

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☐Suicide 4☒Homicide 5☐Pending investigation 6☐Could not be determined	2/11/01	1600PM	1☐Yes 2☑No	Subject Assaulted

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
House	Ellicott City, Maryland

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
J Pestaner, M.D	OCME	FEBRUARY 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 14 2001	Geneva B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04179

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Virginia Hecker

2. Date of Death: Month 02 Dey 06 Year 01

3. Time of Death: 11:45 pm

4a. Facility Name (If not institution, give street and number): Millennium Nursing & Rehab Center

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 218-01-3518

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 14, 1910

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie, MD

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7575 E. Howard Road

10f. Zip Code: 21060

10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Restaurant Manager

16b. Kind of Business/Industry: Service

17. Father's Name (First, Middle, Last): Ira Harry Carpenter

18. Mother's Name (First, Middle, Maiden Surname): Virginia Lee Solomon

19a. Informant's Name/Relationship (Type, Print): Lindalee A. Scherch / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1152 Hull Street, Baltimore Maryland 21230

20a. Method of Disposition: ☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore National Cemetery | Date: Feb. 9, 2001

20c. Location - City or Town, State: Baltimore Maryland

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr. — Victor P. Doda Jr.

22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximete Intervel Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Infarction — 1 day

Due to (or as a consequence of):
b. Essential Hypertension — 25 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: Hyperparathyroidism

23b. Did tobacco usa contribute to the cauea of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Harjit Singh M.D.

29c. License number: D0014160

29d. Date signed (Month, Day, Year): 02/07/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Harjit Singh, M.D. 5410-A Ritchie Highway Baltimore, Md. 21225

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): FEB 14 2001

32. Registrar's Signature: Bonnie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04180

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Betty Lou Heber

2. Date of Death (Month, Dey, Year): FEB. 10, 2001

3. Time of Death: 7:00 AM

4a. Facility Name *(If not institution, give street and number)*: 5667 Landing Road

4b. City, Town, or Location of Death: Elkridge

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 231-34-7210

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: OCT. 9, 1931

9. Birthplece *(Stete or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Elkridge

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 5667 Landing Road

10f. Zip Code: 21075

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - Americen Indien, Bleck, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: School Bus Aide

16b. Kind of Business/Industry: Howard County Schools

17. Father's Neme *(First, Middle, Last)*: Richard Eldridge Henry

18. Mother's Name *(First, Middle, Meiden Surneme)*: Ida Mae Hanlin

19a. Informent's Name/Relationship *(Type, Print)*: William Heber - husband

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, State, Zip Code)*: 5667 Landing Rd., Elkridge, Md. 21075

20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Baltimore Washington Crm. | Date: 2/14/01

20c. Locetion - Clty or Town, Stete: Laurel, Md.

21. Signetura of Funeral Service Licensee: Mark Marshall

22. Name and Address of Facility: Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications thet ceusad the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on each line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Final disease or condition resulting in death): e. MYOCARDIAL INFARCTION — 6 hrs

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in death) Lest

b.

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Pert II. **Other signficant conditions** contributing to death but not rasulting in the underlying ceusa given in Part I.: CHRONIC OBSTRUCTIVE PULMONARY DISEASE; STROKE

23b. Did tobacco uaa contribute to the cause of deeth? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Locetion *(Street end Numbar or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted. 2☐ **Medicel Examiner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner steted.

29b. Signetura and title of certifier

29c. License number: D40012

29d. Date signed *(Month, Dey, Yeer)*: FEBRUARY 12, 2001

30. Neme and address of person who completed causa of death (Item 23a) (Type, Print): SCOTT POULTON, MD 7006 EIPE RD, CATONSVILLE, MD 21228

State Registrar

31. Data filed *(Month, Day, Yeer)*: FEB 14 2001

32. Registrar's Signature: Geneva G. Sparks

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04181

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): STELLA MONROE HIRSCH

2. Date of Death: Month FEBURARY Day 12 Year 2001

3. Time of Death: 4:45 AM

4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLVD.

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 705-05-4069

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 12 1907

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Glen Arm

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 11630 Glen Arm Rd.

10f. Zip Code: 21057

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: USA

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Telephone Operator

16b. Kind of Business/Industry: B&O Railroad

17. Father's Name (First, Middle, Last): William Christopher O'Brien

18. Mother's Name (First, Middle, Maiden Surname): Ada Amelia Bell

19a. Informant's Name/Relationship (Type, Print): Miss Gloria A. Hirsch/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8643 Tower Bridge Way Lutherville, Md. 21093

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery

Date: 2-13-01

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Kurt J. Pauls

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. MYOCARDIAL ISCHEMIA.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: LOWER GASTROINTESTINAL BLEEDING

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rafiq Mar.

29c. License number: D21778

29d. Date signed (Month, Day, Year): FEBURARY 12 2001.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLVD. BALTIMORE MD.

State Registrar

31. Date filed (Month, Day, Year): FEB 14 2001

32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04182

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month Day Year	3. Time of Death
Sophie G. Hanzlik	February 9 2001	7:00 AM

4a. Facility Name (If not institution, giva street and number)	4b. City, Town, or Location of Death	4c. County of Death
Genesis Eldercare	Parkville	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Aga (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-05-6870	1☐ M 2☒ F	89 Yrs.					8-29-1911	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Rosedale	1☐ Yas 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1207 White Avenue	21237	USA

11. Marital Status	12. Was Decedent Evar In U,S. Armed Forcas?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, alc.)	14. Race - American Indian, Black, White, atc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yas 2☒ No If Yes, Giva Year or Datas:	1☐ Yas 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
7	0	Administrative	Hoschild Kohn

17. Father's Name (First, Middle, Last)	18. Mother's Nama (First, Middle, Maiden Sumama)
Joseph Rusinek	Eleanor White

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code)
Thomas Coyne/Son-in-Law	6520 Langdale Road Baltimore MD 21237

20a. Method of Disposition	20b. Place of Disposition (Nama of cematery, cremetory or othar place)	Data	20c. Location - City or Town, Stete
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Garden of Faith Cemetery	2-12-01	Baltimore, MD

21. Signatura of Funeral Service Licensee	22. Nama and Addrass of Facility
▶ [signature]	Cvach/Rosedale Funeral Home 1211 Chesaco Avenue Baltimore MD 21237

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter tha disease, or complications that caused tha death. Do not antar tha moda of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Intervel Between Onset and Death
Immediete Cause (Final disease or condition resulting in death)	a. Pneumonia	days.
	Dua to (or es e consequence of):	
Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequance of):	
	c.	
	Dua lo (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.

Senile Dementia Depression

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Ware autopsy findings available prior to completion of ceuse of death?
1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown	1☐ Yas 2☒ No	1☐ Yes 2☐ No

25. Was cesa referred to medicat axaminer?	26. Place of Deeth (Check only one)	
1☐ Yas 2☒ No	Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Homa 5☐ Residence 6☐ Other (Specify)

27. Mariner of Death	28a. Date of Injury (Month, Dey Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one)	29b. Signatura and title of certifier	29c. License number	29d. Data signed (Month, Day, Year)
1☒ Certifying Physician: To the best of my knowledge, death occurred et tha tima, data end place, and due to the cause(s) end manner es stated. 2☐ Medical Examiner: On tha basis of axamination and/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) end mannar stated.	▶ Martha C. Raymundo MD	D054518	2/9/01

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print)

martha c. raymundo 8007 E ~~Northern~~ Parkway Baltimore MD 21214

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signature
FEB 14 2001	▶ [signature] D. Sparks

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND#8 PER F.H. G793 3-13-2001 JAB

Certificate of Death

Reg. No. 2001 04183

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): NAOMI. A. HUDSON

2. Date of Death: Month FEBUARY Day 11 Year 2001

3. Time of Death: 12:20 AM

4a. Facility Name (If not institution, give street and number): 1706 HILYARD RD.

4b. City, Town, or Location of Death: PARKVILLE

4c. County of Death: BALTIMORE.

Funeral Director

5. Social Security Number: 215-18-0614

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12-22-22 DEC. 12, 1922

9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.

10b. County: BALTIMORE

10c. City, Town or Location: PARKVILLE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1706 HILYARD ROAD

10f. Zip Code: 21234

10g. Citizen of Whet Country? USA

11. Maritel Stetus: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12): 12

College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): CLERK

16b. Kind of Business/Industry: CREDIT BUSI.

17. Fether's Neme (First, Middle, Last): EDWARD LYSTON

18. Mother's Name (First, Middle, Maiden Surname): ELIZABETH SPORER

19a. Informant's Name/Reletionship (Type, Print): NAOMI WELLAND / DAUGHTER

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 415 CEDAR SPRING Rd. BELAIR, Md 21015

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Plece of Disposition (Neme of cemetery, cremetory or other piece): PARKWOOD CEM.

Dete: 2/14/01

20c. Location - City or Town, Stete: BALT. Md.

21. Signeture of Funerel Service Licensee: Paul M Stella

22. Neme end Address of Facility: HARTLEY MILLER FUNERAL HOME, CHTD. 7527 HARFORD Rd BALTO. Md. 21234

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth end Mentel Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Cause (Finel diseese or condition resulting in deeth)

e. Acute Myocardial infarction — hours

Due to (or es a consequence of):

b. Ischemic Cardiomyopathy — years

Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in deeth) Lest

Due to (or es e consequenca of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pharacic Aneurysm

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☐ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Deeth (Check only one)

Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier: C.O

29c. License number: D08358

29d. Date signed (Month, Dey, Year): Feb 12 2001

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): GRACITA V. PATRICIO 8903 HARFORD ROAD BALT. MARYLAND 21234

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funerel director, page 2 should be detached for use as the burial-transit

State Registrar

31. Dete filed (Month, Dey, Yeer): FEB 14 2001

32. Registrer's Signeture: Joanne G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04184

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Agnes Marie Hubbard

2. Date of Death: Month February Day 12 Year 2001

3. Time of Death: 8:15 AM

4e. Facility Name (If not institution, give street and number): Stella Maris Hospice

4b. City, Town, or Location of Death: Timonium

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-07-6089

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 22, 1919

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 315 Worthington Rd.

10f. Zip Code: 21286

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Detas:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12): 12

College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Neme (First, Middle, Last): Charles Lutz

18. Mother's Name (First, Middle, Maiden Surneme): Marie Ritter

19e. Informent's Name/Relationship (Type, Print): Jeannie Hubbard/daughter

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 315 Worthington Rd. Baltimore, MD 21286

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Parkwood Cemetery

Dete: 2/14/01

20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signeture of Funerel Sarvice Licensee: John D. Mitchell IV

22. Nama and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc 6500 York Rd. Baltimore, MD 21212

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Interval Between Onset end Death

Immediete Cause (Finel disease or condition resulting in deeth): e. End Stage Dementia

Due to (or as a consequenca of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events rasulting in death) Last:

b.

Due to (or es e consequence of):

c.

Due to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospitel: 1☐ Inpatiant 2☐ ER/Outpetient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier: [signature] MD

29c. Licensa number: D43725

29d. Data signed (Month, Day, Year): 2/13/01

30. Nama and address of person who complated causa of daath (Item 23a) (Type, Print): Dr. Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 21093

State Registrar

31. Dete filed (Month, Day, Year): FEB 14 2001

32. Registrar's Signatura: [signature]

ORIGINAL

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

February 12, 2001 8:15 a.m.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Agnes Hubbard

01-0776-510 AMEND ITEM: #20A PER F.H. G792 2-14-01 WR.
B.K.S
NANCY JENKINS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 04185

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
NANCY	LOUISIANNA	JENKINS	FEB. 10, 2001	8:35 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
BON SECOUR HOSPITAL	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-22-5440	1☐M 2☒F	78 Yrs.			MARCH 11, 1922	NORTH CAROLINA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	N/A	BALTIMORE CITY	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1510 WEST MOSHER ST.	21217	USA.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Ricen, etc.)	14. Race - American Indian, Black, Whlte, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12TH GRADE		HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Surname)
JAMES KEARNEY	HATTIE LEE

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
VANESSA JENKINS (DAUGHTER)	1124 N. MONROE ST, BALTIMORE, MD. 21217

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, crematory or other place)	Date	20c. Location - City or Town, Stete
1☒Burial 2☒Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)	METRO CREMATORY	02-13-01	BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Richard N. Williams

22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respirelory arrest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Hypertensive Arteriosclerotic Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last

b. Due to (or as e consequence of):

c. Due to (or es e consequence of):

d. Due to (or as a consequence of):

IF FEMALE: 23b. Wes decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnency	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnency 4☐Pregnant et time of deeth 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death?	24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Deeth (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es steted. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	O.C.M.E	FEB. 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARY G. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 14 2001	Geneva D. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04186

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sophia R. Koivula
2. Date of Death: Month: February Day: 9 Year: 2001
3. Time of Death: 2:45 PM
4a. Facility Name (If not institution, give street end number): NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 577-68-0961
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 64 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 17, 1937
9. Birthplace (State or Foreign Country): Germany

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Crownsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 1147 Claire Road
10f. Zip Code: 21032
10g. Citizen of Whet Country?: Germany

11. Maritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Americen Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Salesperson
16b. Kind of Business/Industry: Retail

17. Fether's Neme (First, Middle, Last): Hans Bauer
18. Mother's Name (First, Middle, Maiden Surneme): Sophia Grunert

19a. Informent's Neme/Reletionship (Type, Print): Gunter Bauer/Son
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1419 Cambium Ct. Hanover, MD 21076

20a. Method of Disposition: ☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Meadowridge Mem. Pk. Date: Feb. 16, 2001
20c. Location - City or Town, Stete: Elkridge, MD

21. Signeture of Funeral Service Licensee: Lee L Ebaugh
22. Neme end Address of Fecility: Kirkley-RUddick Funeral Home P.A. 421 Crain Hwy. S.E. GLen Burnie, MD 21061

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or comelications thet ceused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart feilure. List only one cause on eech line. Approximete Interval Between Onset end Death

Immediete Ceuse (Final diseese or condition resulting in deeth)
e. SUBARACHNOID HEMORRHAGE

Due to (or as e consequence of):
b. RUPTURE OF A.A ANEURYSM

Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest

Due to (or es e consequence of):
c.

Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☐ No
24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No
26. Piece of Deeth (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: MD
29c. License number: D43977
29d. Date signed (Month, Dey, Year): February 9 2001

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): Gwoken Dretimyl. 301 Hospital Drive Glen Burnie MD 21061

State Registrar

31. Dete filed (Month, Day, Year): FEB 14 2001
32. Registrer's Signeture: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Koivula Sophia

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04187

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Willie Kennedy
2. Date of Death (Month, Day, Year): Feb 7, 2001
3. Time of Death: 8:20 P.M
4a. Facility Name (If not institution, give street and number): 1354 - Cleveland St.
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N-A

Funeral Director

5. Social Security Number: 249-34-5227
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 67 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 8-17-33
9. Birthplace (State or Foreign Country): Alambama

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 1354 Cleveland St.
10f. Zip Code: 21230
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Freight Helper
16b. Kind of Business/Industry: Shipment Co

17. Father's Name (First, Middle, Last): Gaston Kennedy
18. Mother's Name (First, Middle, Maiden Surname): Sara Brown

19a. Informant's Name/Relationship (Type, Print): Frances Kennedy wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1354 - Cleveland St, Baltimore, MD 21230

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Mem Pk. — Date: 2-13-01
20c. Location - City or Town, State: Glen Burnie, MD

21. Signature of Funeral Service Licensee: Floyd M. Eddy
22. Name and Address of Facility: Estes Bros F. H. Ser. Inc 1300 Eutaw Place, Balto, MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure
Due to (or as a consequence of):
b. Ischemic Heart Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Hypertension
Due to (or as a consequence of):
d. Hypercholesterolemia

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus
Prostate Cancer

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one) — Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Nina F. Everett, MD
29c. License number: D46444
29d. Date signed (Month, Day, Year): 2/9/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nina F. Everett, MD 2323 Orleans St, Balt MD 21224

State Registrar

31. Date filed (Month, Day, Year): FEB 14 2001
32. Registrar's Signature: for D. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 04188

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Leonard Charles Krout

2. Date of Death (Month, Day, Year): February 11, 2001

3. Time of Death: 10:08AM M

4a. Facility Name (If not institution, give street and number): 3416 Chestnut Avenue

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 705-05-3357

6. Sex: 1☐M 2☐F XX

7. Age (In yrs. last birthday): 97 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): February 15, 1903

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐Yes 2☐No XX

10e. Street and Number: 3416 Chestnut Avenue

10f. Zip Code: 21211

10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☐Married 3XXWidowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes XX No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes XX No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk

16b. Kind of Business/Industry: Railroad

17. Father's Name (First, Middle, Last): Charles Krout

18. Mother's Name (First, Middle, Maiden Surname): Mary Elsie Edrington

19a. Informant's Name/Relationship (Type, Print): Leslie Lee Eccleston DTR

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12950 Biggin Church Road South Jacksonville,Florida 32224

20a. Method of Disposition: XX Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Moreland Memorial Park

Date: 2/16/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Dennis A Yeskey Kreake

22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE CEREBROVASCULAR ACCIDENT

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. GENERALIZED ARTERIOSCLEROSIS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

S/P CABG

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Miguel Karacuschansky

29c. License number: D0015462

29d. Date signed (Month, Day, Year): 2/13/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Miguel Karacuschansky 200 East 33rd Street Suite 640 Baltimore, Maryland 21218

State Registrar

31. Date filed (Month, Day, Year): FEB 14 2001

32. Registrar's Signature: Lenora B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04189

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Pashie Lampkin
2. Date of Death Month: 2 Dey: 10 Year: 2001
3. Time of Death: 10 A M.
4a. Facility Neme (If not institution, give street end number): Larkin-Chase Nursing Home
4b. City, Town, or Location of Death: Bowie
4c. County of Deeth: Prince Georges

Funeral Director

5. Social Security Number: 212-22 7219
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. If Under 1 Year: Months / Deys. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): 2/3/13
9. Birthplace (Stete or Foreign Country): FLA.

To Be Completed by Funeral Director

Usuel Residence of Decedent

10a. State: Md
10b. County: N. A
10c. City, Town or Location: 4509 Holmchurst Bowie Md
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 4509 Holmehurst Way
10f. Zip Code: 20220
10g. Citizen of Whet Country?: U.S.A
11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: BLACK
15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 8th; College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Domestic
16b. Kind of Business/Industry: Home Care
17. Fether's Neme (First, Middle, Lest): Jessie Turner
18. Mother's Name (First, Middle, Meiden Surneme): Ida Unknown
19a. Informent's Name/Relationship (Type, Print): George Brapton
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 4509 Holmehurst Way Mitchellville MD 207 20
20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other place): Mt Calvary Cem.
Date: 2/15/01
20c. Locetion - City or Town, Stete: Brooklyn Md.
21. Signature of Funeral Service Licensee: Joseph G. Lockett
22. Name and Address of Feciility: Joseph G. Lockett F/H 1304 N. Central Ave

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Intervel Between Onset end Death

Immediate Cause (Finel diseese or condition resulting in deeth)
e. CEREBROVASCULAR ACCIDENT — 3 YEARS
Due to (or es e consequence of):
b. HYPERTENSION — 10 YEARS

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significent conditions** contributing to deeth but not resulting in the underlying cause given in Part I.
FAILURE TO THRIVE
BREAST CANCER PRIMARY

23b. Did tobacco uee contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☒ **Certifying Phyeiclan:** To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.
2☐ **Medical Examinar:** On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and manner stated.

29b. Signeture end title of certifier: SMathew; M.D
29c. License number: D47604
29d. Dete signed (Month, Dey, Yeer): 2/13/01

30. Name end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print): SOBHAN MATHEW, 2905 MITCHELLVILLE RD., SUITE 104, BOWIE, MD 20716

State Registrar

31. Dete filed (Month, Day, Year): FEB 14 2001
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 72 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04190

PAULA W. LEMMON - FEBRUARY 8, 2001
Baltimore, Maryland 21215-0036 @ 2:15AM

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: PAULA WIETERS LEMMON
2. Date of Death (Month, Day, Year): February 8, 2001
3. Time of Death: 2:15AM
4a. Facility Name *(If not institution, give street and number)*: Gilchrist Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 482-30-9435
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 70 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: February 5, 1931
9. Birthplace *(State or Foreign Country)*: Iowa

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5 Pickford Court
10f. Zip Code: 21286
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Alfred Henry Wieters
18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Mae Clifford

19a. Informant's Name/Relationship *(Type, Print)*: J. Michael Lemmon Jr Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1186 Southview Drive Annapolis Maryland 21401

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Baltimore National Cemetery — Date: 2/12/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Dennis Stephen Kenakos
22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Lung Cancer — 5 months
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)* — 28b. Time of Injury — 28c. Injury at Work? 1☐ Yes 2☐ No — 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* — 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: W. Anthony Riley, MD
29c. License number: D25205
29d. Date signed *(Month, Day, Year)*: February 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Balto. MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 14 2001
32. Registrar's Signature: Geneva G Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #8 PER F.H. G792 2-21-01 AB.

AMENDED ITEM# 20b per fh G792 021501 SS

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04191

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
John	C.	Milburn, Jr.	Feb.	12,	2001	17:59pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
11 West 20th Street Apt. 6-D	Baltimore	NA

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-36-6785	XX 1 M 2 F	61 Yrs.					01-24-~~20~~ 40	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	BAltimore	1 X Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11 West 20th Street Apt.6-D	21218	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.)	14. Race - American Indian, Black, White, etc.
X 1 X Never Married 2 Married 3 Widowed 4 Divorced	1 Yas 2 X No If Yas, Giva Year or Datas: X X	1 Yas X No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th Grade	NA	Cook	Double T. Diner

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John H. Milburn	Evelyn Thomas

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Bertina Young	2808 Carver Road Baltimore, Maryland 21225

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crematory or other place)	Date	20c. Location - City or Town, State
X 1 X Burial 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify)	Voshell Mem. Gardens	2-19-01 ~~01-19-2001~~	Dundalk, MD

21. Signature of Funeral Service Licensee: Francis X. Grace

22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. coronary artery disease	1995
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yas 2 X No	1 Yas 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yas 2 X No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 X Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		M	1 Yas 2 No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Kakembo MD.	D42217	2/13/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
HENRY KAKEMBO MD 448 N. LUZERNE AVE. BALTIMORE MD 21224

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 14 2001	G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04192

MILLER, ELLA

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELLA M MILLER

2. Date of Death (Month, Day, Year): FEBRUARY 10, 2001

3. Time of Death: 3:45 A.M.

4a. Facility Name (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL CENTER

4b. City, Town, or Location of Death: ROSEDALE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 218-16-1730

8. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 4 1925

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md

10b. County: Baltimore

10c. City, Town or Location: Middle River

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 138 East Kingston Park Lane

10f. Zip Code: 21220

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 6th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): Irving G. Tolson

18. Mother's Name (First, Middle, Maiden Surname): Esther Schwertzy

19a. Informant's Name/Relationship (Type, Print): Debra BRadley / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1004 Arncliffe Road BAltimore MD. 21221

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holly Hill Cemetery

Date: 2/14/01

20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: R. Terry Connelly

22. Name and Address of Facility: Connelly Funeral Home of Essex 300 Mace Ave. Baltimore MD. 21221

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Small Cell Cancer of Lung — 2 Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Supraventricular Arrhythmia

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael Auerbach MD

29c. License number: D33551

29d. Date signed (Month, Day, Year): Feb 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL AUERBACH, MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

State Registrar

31. Date filed (Month, Day, Year): FEB 14 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04193

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LILLIE MAE MALONE
2. Date of Death (Month, Day, Year): February 12, 2001
3. Time of Death: 350 pm
4a. Facility Name *(If not institution, give street and number)*: Maryland General Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-28-9087
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: NOV. 03, 1911
9. Birthplace *(State or Foreign Country)*: NORTH CAROLINA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1217 WEST FAYETTE STREET
10f. Zip Code: 21223
10g. Citizen of What Country?: USA.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6TH GRADE | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: WILLIE WEST
18. Mother's Name *(First, Middle, Maiden Surname)*: UNKNOWN

19a. Informant's Name/Relationship *(Type, Print)*: WAVERLY MALONE (SON)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1330 LAURENS STREET, APT 109, BALTO, MD. 21217

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MT. ZION CEMETERY | Date: 02-19-01
20c. Location - City or Town, State: LANSDOWNE, MARYLAND

21. Signature of Funeral Service Licensee: Richard N. Wallace
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO. MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ARRHYTHMIA
Due to (or as a consequence of):
b. CORONARY ARTERY DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] M.D.
29c. License number: P 13526
29d. Date signed *(Month, Day, Year)*: 2/12/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ERIC MARCALUS, M.D. c/o Maryland General Hospital

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 14 2001
32. Registrar's Signature: [signature] G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Lillie Malone

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 04194

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
VERNER B. MARBLE	FEBRUARY 07, 2001	5:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
6015 WESTERN RUN DRIVE	BALTIMORE	BALTIMORE CITY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
079-05-3393	1☒ M 2☐ F	80 Yrs.			JANUARY 29, 1921	NEW YORK

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	BALTIMORE CITY	BALTIMORE	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6015 WESTERN RUN DRIVE	21209	UNITED STATES

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates: 3/66-6/95	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		SGT. MAJOR	UNITED STATES MILITARY

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
CLAUDE MARBLE	ETHEL COOK

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
GLORIA MARBLE-WIFE	6015 WESTERN RUN DRIVE, BALTIMORE, MARYLAND 21209

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, Stete
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	DRUID RIDGE CEMETERY	2-10-2001	BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Lisa L. Jefferson

22. Name and Address of Facility: LOUDON PARK FUNERAL HOME, 3620 WILKENS AVENUE, BALTIMORE, MARYLAND 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death) a.	Hypoxic Arrest	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): b.	Chronic Obstructive Pulmonary Disease	10 years
Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetel deeth 3☐ Ectopic pregnancy 4☐ Pregnant at time of deeth 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

Medical Certification; To Be Completed by Physician/Medical Examiner

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Tyler Cynet, DO	H43157	2/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Tyler Cynet, DO 2435 W Belvidere, Suite 22 Baltimore MD 21215

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 14 2001	Donna D. Sparks

State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04195

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Jennie E. Myers
2. Dete of Deeth — Month: February Dey: 11, Year: 2001
3. Time of Death: 4:30 am
4e. Feciility Neme (If not institution, give street end number): Harbor Hospital Center
4b. City, Town, or Location of Deeth: Baltimore City
4c. County of Deeth: N/A

Funeral Director

5. Sociel Security Number: 214-38-5465
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthdey): 61 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): July 27, 1939
9. Birthplece (Stete or Foreign Country): Maryland

Usuel Residence of Decedent

10e. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1129 Hull Street
10f. Zip Code: 21230
10g. Citizen of Whet Country?: United States

11. Meritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Eduction (Specify only highest grede completed): Elementery/Secondary (0-12): 10 — College (1-4or 5+): 0
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Factory Worker
16b. Kind of Business/Industry: Manufacturing

17. Fether's Neme (First, Middle, Last): Russell L. Kooser
18. Mother's Neme (First, Middle, Meiden Surneme): Jennie E. Kissinger

19a. Informent's Neme/Relationship (Type, Print): Bernard W. Myers / Husband
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 1129 Hull Street, Baltimore Maryland 21230

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Cedar Hill Cemetery, — Date: February 14, 2001
20c. Location - City or Town, State: Baltimore Maryland

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr. ▶ Victor P. Doda, Jr.
22. Name and Address of Feciility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions that caused the deith. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line. — Approximete Interval Between Onset and Death

Immediete Ceuse (Finel diseese or condition resulting in deeth): e. Hypertensive Arteriosclerotic Cardiovascular Disease
Due to (or es e consequence of):
Sequentially list conditions, if eny, leading to immediete ceuse. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Lest:
b. Due to (or es e consequence of):
c. Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: Diabetes Mellitus - Type 2; Hyperlipidemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 1☐ Yes 2☒ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☒ No
26. Piece of Deeth (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☒ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28e. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exemineticn end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner steted.
29b. Signeture end title of certifier: ▶ Jorge Vallecillo
29c. License number: D26203
29d. Date signed (Month, Dey, Year): February 12, 2001
30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Jorge Vallecillo, MD 1319 Light St. Baltimore, MD 21230

State Registrar

31. Dete filed (Month, Dey, Year): FEB 14 2001
32. Registrer's Signature: ▶ Bernice G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 04196

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Leroy Jennings Meadows
2. Date of Death (Month, Day, Year): February 9, 2001
3. Time of Death: 3:15 AM
4a. Facility Name (If not institution, give street and number): 6610 River Drive
4b. City, Town, or Location of Death: Edgemere
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-28-4132
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 20, 1931
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Edgemere
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 6610 River Drive Road
10f. Zip Code: 21219
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1951-55
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Steelworker
16b. Kind of Business/Industry: Steel Industry

17. Father's Name (First, Middle, Last): Roy Meadows
18. Mother's Name (First, Middle, Maiden Surname): Edith Roudabush

19a. Informant's Name/Relationship (Type, Print): Mrs. June Mary Meadows (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6610 River Drive Edgemere, Maryland 21219

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery
Date: 2/12/2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Stephanie Massey
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: 3 1/2 yrs

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Colon Cancer
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.
29c. License number: D45390
29d. Date signed (Month, Day, Year): 2/9/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MYO MIN (M.D.) 8114 SANDPIPER CIRCLE #211, BALTIMORE, MD 21236

State Registrar

31. Date filed (Month, Day, Year): FEB 14 2001
32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 04197

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Thomas R. Martin, Jr.	February 11, 2001	10:15 am M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Manor Care- Rossville	Rossville	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-10-8325	1☒ M 2☐ F	83 Yrs.			February 2, 1918	Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Rosedale	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8015 Neighbors Avenue	21237	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
5		Steel worker	Steel company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Thomas R. Martin, Sr.	Eva Elizabeth Lutsche

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Melva W. Martin-wife	8015 Neighbors Ave., Baltimore, MD 21237

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) Entombment	Gardens of Faith	2/15/01	Baltimore, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ William G. Dau	Leonard J. Ruck Funeral Home, Inc. 5305 Harford Rd., Baltimore, MD 21214

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List *only* one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ATHEROSCLEROTIC CORONARY VASCULAR DISEASE — Approximate Interval Between Onset and Death: 10 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. END STAGE DEMENTIA — 5 years

Due to (or as a consequence of):

c. _____

Due to (or as a consequence of):

d. _____

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnency 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ [signature]

29c. License number D0029197

29d. Date signed (Month, Day, Year) 2/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. M. NICHOLS MD 9101 FRANKLIN SQUARE DR. -205 BALTO, MD 21237

State Registrar

31. Date filed (Month, Day, Year) FEB 14 2001

32. Registrar's Signature ▶ [signature] D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01188

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Eugene Charles Marciszewski
2. Date of Death Month Day Year: FEBRUARY 12, 2001
3. Time of Death: 12:25 AM
4a. Facility Name *(If not institution, give street and number)*: Saint Joseph Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-22-1111
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: November 18, 1927
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 5502 Hilltop Avenue
10f. Zip Code: 21206
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11th Grade; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Maintenance
16b. Kind of Business/Industry: Maryland Historical Society

17. Father's Name *(First, Middle, Last)*: Frank Marciszewski
18. Mother's Name *(First, Middle, Maiden Surname)*: Stella Levendowski

19a. Informant's Name/Relationship *(Type, Print)*: Dorothy Marciszewski/Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5502 Hilltop Avenue Baltimore Maryland 21206

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory, or other place)*: Gardens of Faith Cemetery
Date: 2/16/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Christina L. Hilton — ▶ Christina L. Hilton
22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. METASTATIC RENAL CELL CARCINOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Joginder P Mehta M.D.
29c. License number: D 0041410
29d. Date signed *(Month, Day, Year)*: February 12th, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOGINDER P. MEHTA, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 14 2001
32. Registrar's Signature: ▶ Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04199

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Vincent A. Marchetti
2. Data of Death Month Dey Yaar: February 3, 2001
3. Tima of Death: 10:00am
4a. Facility Nema *(If not institution, giva street and number)*: VAMHCS Fort Howard Division
4b. City, Town, or Location of Death: Fort Howard
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 183072377
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthdey)*: 84 Yrs. — If Under 1 Yeer: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Yaar)*: 6/9/1916
9. Birthplace *(State or Foraign Country)*: Pennsylvania

Usual Rasidance of Dacedent

10a. Stata: MD
10b. County: Baltimore
10c. City, Town or Location: Perry Hall
10d. Insida City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3907 Hannon Court
10f. Zip Coda: 21236
10g. Citizan of What Country?: U.S.A.
11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☒ Yas 2☐ No If Yas, Give Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*
14. Race - Amarican Indian, Black, Whita, atc. *Specify:* White
15. Decedent's Educetion *(Specify only highast grada completed)*: Elamantary/Secondary (0-12): 12 — Collega (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT usa retired)*: Carpenter
16b. Kind of Business/Industry: Bethlehem Steel
17. Father's Nama *(First, Middla, Last)*: Rudolph Marchetti
18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Rose Ann Kane
19a. Informant's Name/Ralationship *(Type, Print)*: Sophie Marchetti/Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Coda)*: 3907 Hannon Ct. Perry Hall, Maryland 21236
20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Nama of cemetary, cramatory or othar place)*: Garrison Forest VA Cem. — Data: 2/7/01
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Sarvice Licensee: Carla R. Gil
22. Nama and Addrass of Facility: John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206

Physician /Medical Examiner

23a. Part I. Enter tha disaasa, or complications that caused tha daath. Do not antar the mode of dying, such as cardiac or raspiratory errast, shock, or haart failure. List only one causa on aach line.

Approximata Intervel Batwaan Onset and Death

Immediata Causa (Final disaasa or condition rasulting in death)
a. Pnuemonia — weeks
Dua to (or as a consequanca of):
b. Dehydration — 2 days
Dua to (or as a consequence of):
Sequantially list conditions, if any, laading to immediata ceusa. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. Dementia — years
Dua to (or as e consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying ceusa givan in Part I.

Crohns Disease

Dehydration

Osteoarthritis

23b. Did tobacco uee contribute to the cause of death? 1☐ Yee 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy parformed? 1☐ Yas 2☒ No

24b. Were autopsy findings eveilabla prior to complation of causa of daath? 1☐ Yes 2☐ No

25. Wes cese rafarred to medical exeminar? 1☐ Yas 2☒ No

26. Placa of Death *(Check only ona)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Deta of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28a. Place of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*
28f. Location *(Straet and Number or Rural Routa Number, City or Town, Stete)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowladga, death occurred at tha tima, data and place, and due to the ceuse(s) and menner as steted. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, death occurred at tha tima, date and plece, and dua to tha causa(s) and manner stated.

29b. Signatura and titla of certifiar: Carolina Custodio MD
29c. Licansa number: D 15628
29d. Data signed *(Month, Day, Year)*: 2/12/01

30. Neme and eddrass of person who completed causa of daath (Item 23a) (Type, Print): Carolina Custodio MD 9600 North Point Rd, Fort Howard, MD 21052

State Registrar

31. Dete filed *(Month, Day, Year)*: FEB 14 2001
32. Registrar's Signatura: Rebecca G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Vincent A. Marchetti
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04200

Patient known as: LENORA H. NAST

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LENORA HEILIG NAST
2. Date of Death (Month, Day, Year): February 10, 2001
3. Time of Death: 7:37 PM
4a. Facility Name (If not institution, give street and number): SINAI Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-24-7860
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): FEB.23,1923
9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: RANDALLSTOWN
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4 WILLOW BROOK COURT
10f. Zip Code: 21133
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5+ College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): THEOLOGIST
16b. Kind of Business/Industry: EDUCATION
17. Father's Name (First, Middle, Last): SIMON HEILIG
18. Mother's Name (First, Middle, Meiden Surneme): EDNA GOLDBERG
19a. Informant's Name/Relationship (Type, Print): RICHARD H. NAST / SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4 WILLOW BROOK COURT - RANDALLSTOWN, MD 21133
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Placa of Disposition (Name of cemetery, crematory or other placa): OHEB SHALOM MEMORIAL PARK
Date: 2/13/01
20c. Location - City or Town, State: REISTERSTOWN, MD
21. Signature of Funaral Service Licensee: [signature]
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — 48hours

Due to (or es e consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents rasulting in death) Last

b. Due to (or es e consequenca of):

c. Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uss contributa to the causa of death? 1☐ Yss 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Ware autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residance 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end placa, and due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD, PGY-1
29c. Licensa number: RES000
29d. Date signed (Month, Day, Year): FEBRUARY 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SINAI Hospital of Baltimore 2401 West Belvedere Ave. Baltimore Maryland 21215

State Registrar

31. Dete filed (Month, Day, Year): FEB 14 2001
32. Registrar's Signeture: [signature]

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attanding physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

ITEM#30 (PER D,V,R,) G792 2-14-2001 JAB

Reg. No. 2001 04201

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Jean O'Keefe

2. Dete of Deeth — Month: February Day: 11 Year: 2001

3. Time of Deeth: 11:15 a.m.

4a. Facility Neme (If not institution, give street end number): Manor Care Ruxton

4b. City, Town, or Location of Deeth: Ruxton

4c. County of Deeth: Baltimore

Funeral Director

5. Social Security Number: 213-26-6019

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 27, 1929

9. Birthplece (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 302 East Joppa Road #403

10f. Zip Code: 21286

10g. Citizen of Whet Country?: U.S.A.

11. Marital Stetus: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 12 yrs. College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Accounts Manager

16b. Kind of Business/Industry: Loyola Federal

17. Father's Name (First, Middle, Last): Lawrence E. Cooney, Sr.

18. Mother's Name (First, Middle, Maiden Surneme): Loretta Catherine Meehan

19a. Informent's Neme/Relationship (Type, Print): Richard R. O'Keefe, Jr./Son

19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): P.O. Box 1397 Sykesville, Maryland 21784-1397

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Dulaney Valley Mem. Gard. Date: 2/15/01

20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: Earl J. Long

22. Name end Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 21204

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line.

Approximete Interval Between Onset end Death

Immediate Cause (Final diseese or condition resulting in death) a. carcinoma of Colon — 1yr

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Lest

b.

Due to (or es e consequence of):

c.

Due to (or es e consequenca of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of deeth? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D-12849

29d. Dete signed (Month, Day, Year): 2-11-01

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print): ABDOLHAMID GHILADI MANOR CARE RUXTON BALTIMORE MARYLAND

State Registrar

31. Dete filed (Month, Dey, Year): FEB 14 2001

32. Registrer's Signature: Bonnie B Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 04202

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Philip Lee Poulson

2. Date of Death (Month, Day, Year): FEBRUARY 10, 2001

3. Time of Death: 6:32 A.M.

4a. Facility Name (If not institution, give street and number): 3737 CLARKS LANE #302

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 224-28-5898

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC. 8, 1921

9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 3737 CLARKS LANE #302

10f. Zip Code: 21215

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1943-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+): 2 1/2 yrs.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): POASTAL WORKER

16b. Kind of Business/Industry: U.S.MAIL

17. Father's Name (First, Middle, Last): LEROY JOYNER

18. Mother's Name (First, Middle, Maiden Surname): LUCILLE POULSON

19a. Informant's Name/Relationship (Type, Print): MRS. FANNIE B. POULSON-WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3737 CLARKS LANE# 302 BALTO. MD. 21215

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): GARRISON FOREST VET.

Data: 2/16/01

20c. Location - City or Town, State: OWINGS MILLS, MD.

21. Signature of Funeral Service Licensee: Lewis T. Gwynn — LEWIS T. GWYNN

22. Name and Address of Facility: LEWIS T. GWYNN FUNERAL HOME 4517 PARKHEIGHTS AVE. BALTO. MD. 21215-6393

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MULTIPLE SCLEROSIS — 35 Yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dr Sunshine MD

29c. License number: P15140

29d. Data signed (Month, Day, Year): FEBRUARY 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. SUNSHINE MD 6210 PK Hts Ave, Balt, MD 2125

State Registrar

31. Date filed (Month, Day, Year): FEB 14 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-0728-027
MICHAEL JOSEPH PARRISH

ASP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED# 23a,b,27,28a-f per ME G795-052001-SS

Certificate of Death

Reg. No. 2001 04203

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Michael J. Parrish

2. Date of Death: Month FEBRUARY Day 09 Year 2001

3. Time of Death: 0450 M

4a. Facility Name (If not institution, give street and number): 7056 DUCKETTS LANE #102

4b. City, Town, or Location of Death: ELKRIDGE

4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 219-70-6003

6. Sex: 1 ☐ M 2 ☐ F — X

7. Age (In yrs. last birthday): 33 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Yaar): DEC. 14, 1967

9. Birthplace (Stata or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. Stata: MD

10b. County: Howard

10c. City, Town or Location: Elkridge

10d. Inside City Limits: 1 ☐ Yas 2 ☐ No X

10e. Street and Number: 7056 Ducketts Lane, Apt. 102

10f. Zip Coda: 21075

10g. Citizan of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1 ☐ Yes 2 ☒ No — If Yes, Give Yaar or Dates: X

13. Was Dacadant of Hispanic Origin? (Spacify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☐ Yas 2 ☒ No Specify:

14. Raca - Amarican Indian, Black, White, atc. Specify: white

15. Decedent's Education (Specify only highast grada complatad)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired): Steel Erector

16b. Kind of Businass/Industry: Superior Steel Erector, Inc.

17. Fathar's Name (First, Middla, Last): Leroy William Parrish

18. Mother's Name (First, Middla, Maidan Surnama): Patricia J. Bergen

19a. Informant's Name/Ralationship (Type, Print): Cathy Parrish - wife

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 7056 Ducketts Lane, Apt. 102, Elkridge, Md. 21075

20a. Mathod of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify)

20b. Placa of Disposition (Nama of cematary, cramatory or other place): Baltimore Washington Crm. Data: 2/17/01

20c. Location - City or Town, Stata: Laurel, Md.

21. Signature of Funeral Service Licensee: Mgk. Maskey

22. Nama and Address of Facility: Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused the daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona cause on each lina. (Approximata Intarval Batwaan Onset and Death)

Immediate Cause (Finel disease or condition rasulting in daath): a. SEIZURE DISORDER IN ASSOCIATION WITH SLEEP APNEA AND LARYNGEAL EDEMA

Dua to (or as a consequence of):

Sequentially list conditions, if any, laading to immediata cause. Entar Undarlying Cause (Disaase or injury that initiated events rasulting in daath) Last: b. MULTIPLE INJURIES

Dua to (or as a consaquence of):

c.

Due to (or as a consaquence of):

d.

IF FEMALE:

23b. Was decedent pregnant in tha past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yas, outcome of pregnancy: 1 ☐ Liva birth 2 ☐ Fatal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnent at tima of daath 5 ☐ Othar (specify) 9 ☐ Unknown

23d. Data of dalivary: Month Day Year

Part II. **Othar significant conditions** contributing to death but not resulting in the underlying causa givan in Part I.

23a. Did tobacco usa contributa to tha causa of daath? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy parformad? 1 ☒ Yas 2 ☐ No

24b. Wara autopsy findings available prior to completion of causa of death? 1 ☒ Yas 2 ☐ No

25. Was case referrad to medical examiner? 1 ☒ Yas 2 ☐ No

26. Placa of Daath (Chack only one): Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA — Othar: 4 ☐ Nursing Homa 5 ☐ Residance 6 ☒ Othar (Specify) SCENE

27. Mannar of Death: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicida 4 ☐ Homicida 5 ☐ Pending investigation 6 ☐ Could not be datarmined

28a. Data of Injury (Month, Day Yaar): 9-10-96

28b. Tima of Injury: 11:14 AM

28c. Injury at Work? 1 ☒ Yes 2 ☐ No

28d. Dascribe how injury occurred: subject fell at work

28e. Placa of Injury - At homa, farm, streat, factory, office building, etc. (Specify): construction site

28f. Location (Street and Numbar or Rural Routa Numbar, City or Town, State): Court Shoe Warehouse 845 Hampton Pk Blvd., Capitol Hgts, MD

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Cartifiar (Check only one): 1 ☐ **Certifying Physician:** To tha bast of my knowledga, daath occurrad at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2 ☒ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha time, date and place, and due to tha causa(s) and mannar stated.

29b. Signatura and litla of cartifiar: M.D.

29c. Licansa number: O.C.M.E

29d. Data signed (Month, Day, Yaar): FEBRUARY 09, 2001

30. Nama and addrass of parson who complatad cause of daath (Item 23a) (Typa, Print): MARY G. RIPPLE, MD. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Yaar): FEB 14 2001

32. Registrar's Signatura: G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 04204

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
CLIFTON	CONLYN	PRESSER, M.D.	February 12, 2001	9:20 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1207 Brook Meadow Dr.	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-32-4084	1☒ M 2☐ F	65 Yrs.			Apr. 2, 1935	Md.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Baltimore	Towson	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1207 Brook Meadow Dr.	21286	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
12	5+	Gynocologist	Medical

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Clifton Presser	Helen Belschner

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ruth E. Presser/wife	1207 Brook Meadow Dr. Towson, Md. 21286

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Hilltop Service Corp.	2/13/01	Towson, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)	a. SUICIDE Gunshot wound HEAD	5minutes
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnent in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnency 4☐ Pregnent at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined	02-12-01	9:18 A M	1☐ Yes 2☒ No	Self inflicted Gun Shot wound to Head

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
At home	1207 Brook Meadow Dr. Towson, MD 21286

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD Deputy	D18667	February 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PHILIP MILITELLO SHOCK TRAUMA 22 S. Greene ST. Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 14 2001	▶ Geneva B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04205

PLAENKER, CARL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Carl F. Plaenker
2. Date of Death: Month 02 Day 11 Year 2001
3. Time of Death: 8:00 AM
4a. Facility Name (If not institution, give street and number): 8820 Walther Blvd. apt. 2313
4b. City, Town, or Location of Death: Parkville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-10-3850
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 92 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 01/31/1909
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8820 Walther Blvd. apt. 2313
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 1942-1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Investment Banker
16b. Kind of Business/Industry: Banking

17. Father's Name (First, Middle, Last): Frederick Carl Adolph Plaenker
18. Mother's Name (First, Middle, Maiden Surname): Johanna Winterling

19a. Informant's Name/Relationship (Type, Print): Mildred E. Plaenker / spouse
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8820 Walther Blvd. apt 2313;Parkville, MD 21234

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetary, cremetory or other place): Parkwood Cemetery
Date: 2/14/01
20c. Location - City or Town, State: Parkville, MD

21. Signature of Funeral Service Licensee: Peter V. Clancy
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, MD 21204

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. ACUTE MYOCARDIAL INFARCTION — hours.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kendall R Faulkner
29c. License number: D25643
29d. Date signed (Month, Day, Year): 02/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KR Faulkner MD / 8800 Walther Blvd / Baltimore MD 21234

State Registrar

31. Date filed (Month, Day, Year): FEB 14 2001
32. Registrar's Signature: Penny B Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04206

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Marie Elizabeth Quinn
2. Date of Death (Month, Day, Year): February 12, 2001
3. Time of Death: 9:00 AM

4a. Facility Name *(If not institution, give street and number)*: Lorien Nursing & Rehabilitation Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-20-2399
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 96 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: December 2, 1904
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4231 Nicholas Avenue
10f. Zip Code: 21206
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Eduction *(Specify only highest grade completed)*
Elementery/Secondery (0-12): 10th Grade
College (1-4or 5+): N/A
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Office Manager
16b. Kind of Business/Industry: Chemical Industry

17. Father's Neme *(First, Middle, Last)*: Nicholas Ellinghaus
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Margaret O'Leary

19a. Informent's Neme/Relationship *(Type, Print)*: John J. Quinn, Sr./Son
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 2009 Tiffany Terrace Forest Hill MD 21050

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, crematory or other piece)*: Most Holy Redeemer
Dete: 2/16/01
20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signature of Funerel Service Licensee: Christina L. Hilton
▶ Christina L. Hilton
22. Neme and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, MD 21214

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heart feilure. List only one cause on each line.

Approximete Interval Between Onset end Deeth

Immediate Cause (Finel disease or condition resulting in deeth)
e. ASPIRATION PNEUMONIA — 1 day

Due to (or as a consequence of):
b. DEMENTIA — 2 yrs

Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last

Due to (or es e consequence of):
c.

Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings aveileble prior to completion of ceuse of deeth? 1☐ Yes 2☒ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end manner steted.

29b. Signeture and title of certifier: ▶ Matthew McNabney MD
29c. License number: D45757
29d. Date signed *(Month, Dey, Year)*: FEB 13, 2001

30. Neme and address of person who completed ceuse of deeth (Item 23a) (Type, Print): MATTHEW McNABNEY 5505 HOPKINS Bayview Circle BALT MD 21224

State Registrar

31. Dete filed *(Month, Dey, Year)*: FEB 14 2001
32. Registrer's Signeture

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #12 PER F.H. G792 2-28-01 WR.

AMEND ITEM: 23 PART I PER MD G792 2-14-01 WR.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2001 04207

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mare-Lynn Maxwell Rollins
2. Date of Death Month/Day/Year: FEB 08 2001
3. Time of Death: 10:10 AM
4a. Facility Name (If not institution, give street and number): Gilchrist Hospice Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 173-40-2418
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 55 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 29, 1945
9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1450 Langford Road
10f. Zip Code: 21207
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+): 3yrs
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LPN
16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Ernest S. Sutton
18. Mother's Name (First, Middle, Maiden Surname): Hattie C. Harris

19a. Informant's Name/Reletionship (Type, Print): Marvin D. Rollins-Hus.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1450 Langford Rd. Balto. Md. 21207

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory
Date: 2/12/01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Glenn B. Yake
22. Name and Address of Facility: March Funeral Home West, Inc 4300 Wabash Ave. Balto. Md. 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SYSTEM LUPUS ERYTHEMATOSUS -SLE — 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Cardiomyopathy, PVD

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D0051926
29d. Date signed (Month, Day, Year): Feb 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Helen M Gordan MD 6565 N. Charles St, Baltimore MD 21204

State Registrar

31. Date filed (Month, Day, Year): FEB 14 2001
32. Registrar's Signature: [illegible] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

2/8/01 10:10A

Rollins, Mare-Lynn

10:10 AM

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04208

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Nicholas Ranaudo

2. Data of Death: Month FEB. Day 10, Year 2001

3. Tima of Death: 12:05 PM

4a Facility Name (If not institution, give street and number): Lorien Nursing Home

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 577-50-2703

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 63 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAY 4, 1937

9. Birthplaca (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Jessup

10d. Insida City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 8376 Ashwood Rd.

10f. Zip Code: 20794

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedant Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, Whita, atc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 / Collega (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cook/Banquet Manager

16b. Kind of Business/Industry: Food

17. Fathar's Nama (First, Middle, Last): Anthony Ranaudo

18. Mother's Name (First, Middle, Maiden Sumame): Mary Ricco

19a. Informant's Name/Relationship (Type, Print): Elizabeth Ranaudo - wife

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code): 8376 Ashwood Rd., Jessup, Md. 20794

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or othar place): Meadowridge Memorial Pk.

Date: 2/15/01

20c. Location - City or Town, State: Elkridge, Md.

21. Signature of Funeral Sarvice Licensee: ▶ Mark Marshall

22. Name and Address of Facility: Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic avant, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter tha disease, or complications that ceused tha daath. Do not antar the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each lina.

		Approximate Intarval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Cardiomyopathy	yrs
Dua to (or as a consequance of): b.	Hypertension	yrs
Sequentially list conditions, if any, laading to immediate causa. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last — Due to (or as a consequence of): c.	Chronic Renal Failure	1 yr
Due to (or as a consequence of): d.	Diabetes Mellitus	yrs.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying causa givan in Part I.: Chronic leg ulcers, congestive heart failure, diabetic neuropathy, hyperlipedemic

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of causa of death? 1 [ ] Yes 2 [ ] No

25. Was casa referred to medicat examinar? 1 [ ] Yes 2 [X] No

26. Placa of Death (Check only ona): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Mannar of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Dascribe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledga, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at tha tima, date and place, and due to tha cause(s) and mannar stated.

29b. Signature and title of certifier: ▶ Christine A. Marin MD Family Physician

29c. License number: D0026264

29d. Data signad (Month, Day, Year): 2/12/01

30. Nama and address of person who complated causa of daath (Item 23a) (Type, Print): Christine A. Marin MD Two Knoll North Drive, Columbia, Md 21045

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Data filed (Month, Day, Year): FEB 14 2001

32. Registrar's Signatura: ▶ Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04209

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Nellie Aldean Rider

2. Date of Death (Month, Day, Year): February 12, 2001

3. Time of Death: 1:20a.m.

4a. Facility Name (If not institution, give street and number): Oak Crest

4b. City, Town, or Location of Death: Parkville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-34-7522

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 95 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): September, 26, 1905

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Monkton

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 15113 Jarrettsville Pike

10f. Zip Code: 21111

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cafeteria Assisant

16b. Kind of Business/Industry: Carroll Manor School

17. Father's Name (First, Middle, Last): Clarence D. Wilson

18. Mother's Name (First, Middle, Maiden Sumeme): Katie I. Stitley

19a. Informent's Neme/Relationship (Type, Print): Rodney Rider/son

19b. Meiting Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 7016 River Drive Rd., Baltimore, Md. 21219

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): St.John's Lutheran Cem.

Date: 2/14/01

20c. Location - City or Town, Stete: Sweet Air, Md.

21. Signature of Funerel Service Licensee: ▶ Wallace S. Brooks, Jr.

22. Neme and Address of Fecility: Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, Md. 21204

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart teilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediate Cause (Finel disease or condition resulting in deeth)

e. LIVER METASTASES — >12mos.

Due to (or es e consequence of):

b. COLON CANCER — 18 mos.

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet Initieted events resulting in deeth) Last

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

Arteriosclerotic cardiovascular disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one) Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the besis of exemineticn end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner steted.

29b. Signature end title of certifier: ▶ Kendall Powers

29c. License number: D 05643

29d. Date signed (Month, Dey, Year): 02/12/01

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): W Faulkner MD 8600 Walther Blvd / Baltimore MD 21234

State Registrar

31. Dete filed (Month, Day, Year): FEB 14 2001

32. Registrar's Signeture: Jeanne E Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed with all known facts after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Nellie Aldean Rider 2/12/01 10:30 Am

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04210

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: James Stephen Sfekas
2. Data of Death Month Day Year: Feb. 12, 2001
3. Time of Death: 7:20 AM
4a Facility Name *(If not institution, give street and number)*: Stella Maris Hospice
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-07-1553
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Aug. 25, 1918
9. Birthplace *(State or Foreign Country)*: Wisconsin

Usual Residance of Decedant

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3 Southerly Court Apt. 608
10f. Zip Coda: 21286
10g. Citizan of What Country?: U.S.A.
11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☒ Yas 2☐ No If Yas, Giva Yaar or Datas: WWII
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*
14. Race - Amaricen Indian, Black, Whita, atc. *Specify:* White
15. Decedent's Education *(Specify only highast grada completed)*: Elamantary/Secondary (0-12); Collega (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Judge
16b. Kind of Businass/Industry: Law
17. Fathar's Nama *(First, Middla, Last)*: Steven Sfekas
18. Mothar's Nama *(First, Middla, Maidan Sumama)*: Stella Poulos
19a. Informant's Name/Ralationship *(Type, Print)*: Mrs. Litsa Sfekas/Wife
19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 3 Southerly Ct. Apt. 608 Towson, Maryland 21286
20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Nama of cematary, cramatory or othar place)*: Greek Orthodox Cemetery
Data: 2/15/01
20c. Locetion - City or Town, Stata: Baltimore, Maryland
21. Signatura of Funaral Sarvice Licensee: Michael J. Ruck
22. Nama and Addrass of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

FEBUARY 12, 2001 7:20 a.m.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

23a. Part1. Entar tha diseasa, or complications that ceuses the death. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batween Onsat and Daath

Immediata Causa (Final disaasa or condition resulting in death)
a. CEREBROVASCULAR ACCIDENT
Dua to (or as a consequance of):

Sequantially list conditions, if any, leading to immadiata ceuse. Entar Undarlying Cause (Disease or Injury that initiated evants resulting in death) Last
b.
Dua to (or as a consequance of):
c.
Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to compiation of ceusa of daath? 1☐ Yas 2☐ No

25. Was cesa rafarred to medicel examinar? 1☐ Yas 2☒ No

26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Othar: 4☐ Nursing Homa 5☐ Residence 6☒ Othar *(Specify)* HOSPICE

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar stated.

29b. Signatura and titla of cartifiar:
29c. Licensa number: D43725
29d. Data signed *(Month, Day, Year)*: 2/13/01

30. Nama and addrass of person who completed ceusa of daath (Item 23a) (Type, Print): DR. TARQI MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

JAMES SFEKAS

State Registrar

31. Data filed *(Month, Day, Year)*: FEB 14 2001
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04211

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Michael Salkaukas
2. Date of Death (Month, Day, Year): February 10, 2001
3. Time of Death: 8:22 PM
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital
4b. City, Town, or Location of Death: Rossville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-50-3106
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 51 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 8/14/1949
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 845 Maple Crest Drive
10f. Zip Code: 21220
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Microbiology Specialist
16b. Kind of Business/Industry: Quest Inc. (Medical)

17. Father's Name (First, Middle, Last): Victor Salkaukas
18. Mother's Name (First, Middle, Maiden Surname): Alberta Mickus

19a. Informant's Name/Relationship (Type, Print): Ira Salkaukas/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 845 Maple Crest Drive Baltimore, Maryland 21220

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest VA. Cem.
Date: 2/15/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardio-pulmonary arrest — 20 minutes
Due to (or as a consequence of):
b. Acute Myocardial Infarction.
Due to (or as a consequence of):
c. Coronary Heart disease.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypertension.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] (M.D)
29c. License number: D-17992
29d. Date signed (Month, Day, Year): 2/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KHIN M. TUN. 1312 Goucher Blvd. Towson md 21286.

State Registrar

31. Date filed (Month, Day, Year): FEB 14 2001
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04212

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERT MITCHELL SILLIMAN
2. Date of Death (Month, Day, Year): February 11, 2001
3. Time of Death: 11:55 P.M.
4a. Facility Name (If not institution, give street and number): Roland Park Place
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 579-50-6473
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 5, 1913
9. Birthplace (State or Foreign Country): Minnesota

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 830 W. 40th. Street
10f. Zip Code: 21211
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedant Evar in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, Whita, etc. Specify: White

15. Decedent's Education (Specify only highest grada completed): Elementary/Secondary (0-12): | Collega (1-4or 5+): 5+ years
18a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired): Consultant Radio Engineer
16b. Kind of Business/Industry: Radio Broadcast

17. Father's Name (First, Middle, Last): Thomas Boughton Silliman
18. Mother's Name (First, Middle, Maiden Surname): Lucille Williams

19a. Informent's Name/Reletionship (Type, Print): Mary Gibson (daughter)
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 6414 Pinehurst Road Baltimore, Maryland 21212

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Green Mount Crematory
Dete: 2-14-01
20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signature of Funeral Service Licensee: George J. Ferraro
22. Name and Address of Fecility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part 1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onsat and Daath
Immediete Ceuse (Final disease or condition resulting in death) a.	ASPIRATION PNEUMONIA (RECURRENT)	7 DAYS
Due to (or es a consequence of): b.	DYSPHAGIA	4 YRS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	CEREBROVASCULAR ACCIDENT	4 YRS
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse givan in Part I.: ATRIAL FIBRILLATION

23b. Did tobacco use contributa to the causa of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was en autopsy performed? 1 [ ] Yas 2 [X] No

24b. Were autopsy findings available prior to completion of cause of deeth? 1 [ ] Yes 2 [X] No

25. Was case referred to medicel examiner? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Deeth: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Yaar)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, and due to the ceuse(s) end menner es stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end mannar stated.

29b. Signature and title of certifier: [illegible] MD
29c. Licansa number: 12399
29d. Date signed (Month, Dey, Year): February 13, 2001

30. Neme and address of person who completed ceusa of deeth (Item 23a) (Type, Print): CHARLES O'DONOVAN III MD 656 N. CHARLES ST #509 BALTIMORE, MD 21201

State Registrar

31. Dete filed (Month, Dey, Year): FEB 14 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

LEON TAYLOR
B.K.S
01-0716-510

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM 23a-ptI,27,28a-f per ME G794 041101 SS
AMENDED#23a,ptII,27 per ME G793 031001 SS

Certificate of Death

Reg. No. 2001 04213

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Leon Taylor	FEB. 8, 2001	12:18 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
UNION MEMORIAL HOSPITAL E.R.	BALTIMORE	NA

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-44-7078	1☐M 2☐F XX	54 Yrs.			05-12-46	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	X1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3522 Old York Road	21218	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married X☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes X2☐No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th Grade	2yrs.	Full-time	Mass Transit Administration

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Taylor	Louise Taylor

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Vernetta Taylor	3522 Old York Road Baltimore, Maryland 21218

20e. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Woodlawn Cemetery	02-15-2001	Woodlawn, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Francis Hunt	Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. — Approximete Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in deeth): a. ~~INTRA-CEREBRAL HEMORRHAGE~~ HEAD INJURIES ASSOCIATED WITH ACUTE ALCOHOL INTOXICATION

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. HYPERTENSION

Due to (or es e consequence of):

c. _____

Due to (or as e consequence of):

d. _____

IF FEMALE: 23b. Was decedent pregnant in the pest 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnent at time of deeth 5☐Other (specify) _____ 9☐Unknown	23d. Date of delivery Month Day Year

Pert II. **Dther significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

SEIZURE DISORDER; ALCOHOLISM

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24e. Was en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of deeth?
1☒Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1~~☒Natural~~ 2☒Accident 3☐Suicide 4☐Homicide 5~~☒Pending investigation~~ 6☐Could not be determined	found: 2-8-01	unknown M	1☐Yes 2☐No unknown	subject fell

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
unknown	unknown

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2☒ **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Stephen S. Radentz, M.D.	O.C.M.E	FEB. 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 14 2001	▶ Bernice G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04214

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Townes
2. Date of Death (Month, Day, Year): Jan 21 2001
3. Time of Death: 4:45 PM
4a. Facility Name (If not institution, give street and number): Mariner Health of Catonsville
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-56-1112
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 73 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb 24, 1927
9. Birthplace (State or Foreign Country): NC

Usual Residence of Decadent

10a. State: MD
10b. County: Baltimore City
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 2405 Annapolis Road
10f. Zip Code: 21230
10g. Citizen of Whet Country?: USA

11. Maritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decadent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decadent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Raca - American Indian, Black, White, etc. Specify: USA

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4or 5+): 0
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Fether's Name (First, Middle, Last): Saul Alston
18. Mother's Name (First, Middle, Meiden Surneme): Nannie Davis

19a. Informant's Name/Reletionship (Type, Print): James Townes / Husband
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 2405 Annapolis Road, Baltimore City MD 21230

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other pleca): Greenwood Bapt. Church Cemetery
Date: Jan. 27, 2001
20c. Location - City or Town, State: Warrenton, NC

21. Signature of Funeral Servica Licensee: Victor P. Doda, Jr.
22. Name end Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue Baltimore Maryland

Physician /Medical Examiner

23a. Part1. Enter the disease, or compiicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Finai disease or condition resulting in death)
a. myocardial infarction — 1d

Due to (or as a consequence of):
b. severe peripheral vascular disease — 1yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Lest
Due to (or as e consequence of):
c. atherosclerotic disease — 5yr.
Due to (or as e consequence of):
d. Diabetes Mellitus — 10yr

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Piece of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and manner es steted. 2☐ Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Physician
29c. License number: D29769
29d. Date signed (Month, Dey, Year): JAN/22/01

30. Name and eddress of person who completed cause of death (Item 29a) (Type, Print): Marcelina D. Abuerne MD 5/6 N. Rolling Rd Balto Md 21228

State Registrar

31. Dete filed (Month, Day, Year): FEB 14 2001
32. Registrar's Signature: Bonnie G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

RKD

01-0792-027

THUY

VO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 04215

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Thuy Kim Thi Vo	FEBRUARY 11,2001	8:09A. M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
HOWARD COUNTY GENERAL HOSPITAL	COLUMBIA	HOWARD

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214.39.8324	1☐M XXF	26 Yrs.			Sept.15,1974	Vietnam

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Howard	Elkridge	1☐Yes 2☐No XX

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6463 Meadowridge Road	21075	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married XX 3☐Widowed 4☐Divorced	1☐Yes 2☒No X If Yes, Give Year or Dates:	1☐Yes 2☒No X Specify:	Specify: Asian

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Manicurist	True Nail, Inc.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Te Nguyen	Vo Thi Tot

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Loc Dinh/ Husband	6463 Meadowridge Rd. Elkridge, MD 21075

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Meadowridge Mem.Pk.	2/17/01	Elkridge, MD

21. Signature of Funeral Service Licensee ▶ Kathy Price

22. Name and Address of Facility: Gary L. Kaufman Funeral Home at Meadowridge Memorial Park 7250 Washington Blvd. Elkridge, MD 21075

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Subarachnoid Hemorrhage

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Rupture OF Cerebral

Due to (or as a consequence of):

c. Artery Aneurysm

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☒Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☒Unknown

23d. Date of delivery Month Day Year: October of 2000

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☑Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☑Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☒ER/Outpatient X 3☐DOA

Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ J. Pestaner, M.D.	O.C.M.E.	FEBRUARY 12,2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date Filed (Month, Day, Year)	32. Registrar's Signature
FEB 14 2001	▶ Bruce D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar ITEM#30 (PER D.V.R.) G792 2-14-2001 JAB

Certificate of Death

Reg. No. 2001 04216

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Anthony Ventura
2. Date of Death: Month February Day 09, Year 2001
3. Time of Death: 11:00 P.M
4a. Facility Name (If not institution, give street and number): 1 Hay Pasture Court
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore Co.

Funeral Director

5. Social Security Number: 215-12-7506
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): November 03,1920
9. Birthplace (State or Foreign Country): Baltimore, Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore Co.
10c. City, Town or Location: Catonsville
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 1 Hay Pasture Court
10f. Zip Code: 21228
10g. Citizen of What Country?: United States of America

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: W.W.II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 04
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Investment Banker
16b. Kind of Business/Industry: Alexander Brown

17. Father's Name (First, Middle, Last): Francesco Ventura
18. Mother's Name (First, Middle, Maiden Surname): Agatha Libertini

19a. Informant's Name/Relationship (Type, Print): (Wife) Mrs. Emma Alexine(nee Insley)Ventura
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1 Hay Pasture Court Catonsville, Maryland 21228

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) Entombment
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Memorial Gd. | Date: 02/12/2001
20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: Ralph L. Young
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Finel disease or condition resulting in death): a. Ischemic Cardiomyopathy 2° to ASCVD — Approximate Interval Between Onset and Death: years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or es a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnency 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ralph L Young
29c. License number: D13272
29d. Date signed (Month, Day, Year): 2-12-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT E. STONER 22 DULANEY HILLS COURT COCKEYSVILLE MARYLAND 21030

State Registrar

31. Date filed (Month, Day, Year): FEB 14 2001
32. Registrar's Signature: Geneva B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-0791-510

B.K.S

DeANDRE WASHINGTON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM#1 per ME G794 041301 SS AMENDED#1,23& 27 per ME G793 031401 SS

Certificate of Death

Reg. No. 2001 04217

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last) DeAndre ~~D Andre~~ Delroy Washington ~~DeANDRE DELROY WASHINGTON GREEN~~

2. Date of Death Month FEB. Day 11, Year 2001

3. Time of Death 1705 PM M

4a. Facility Name (If not institution, give street and number) ST.AGNES HOSPITAL

4b. City, Town, or Location of Death BALTIMORE

4c. County of Death N/A

Funeral Director

5. Social Security Number 216-59-9346

6. Sex 1 X M 2 ☐ F

7. Age (In yrs. last birthday) 0 Yrs. If Under 1 Year: Months 3, Days; If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year) NOV. 05, 2000

9. Birthplace (State or Foreign Country) MARYLAND

Usual Residence of Decedent

10a. State MARYLAND

10b. County N/A

10c. City, Town or Location BALTIMORE CITY

10d. Inside City Limits 1 X Yes 2 ☐ No

10e. Street and Number 2708 WEST NORTH AVE. 3RD FL.

10f. Zip Code 21216

10g. Citizen of What Country? USA

11. Marital Status 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): N/A College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A

18b. Kind of Business/Industry N/A

17. Father's Name (First, Middle, Last) DELROY WASHINGTON

18. Mother's Name (First, Middle, Maiden Surname) JEANNETTE GREEN

19a. Informant's Name/Relationship (Type, Print) JEANNETTE GREEN (MOTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2708 W. NORTH AVE., BALTIMORE, MD. 21216

20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION (BABYLAND) Date 02-19-01

20c. Location City or Town, State LANSDOWNE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility JOSEPH A. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. TETRALOGY OF FALLOT

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnent in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnancy 4 ☐ Pregnent at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ✓ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ✓ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 X Yes 2 ☐ No

26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 X Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier J. Pestaner M.D.

29c. License number O.C.M.E

29d. Date signed (Month, Day, Year) FEB. 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year) FEB 14 2001

32. Registrar's Signature Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04218

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Joan Webster

2. Dete of Death Month Dey Yeer: February 10, 2001

3. Time of Death: 11:35 pm

4a Facility Neme *(If not institution, give street and number)*: 2310 Lodge Farm Rd.

4b. City, Town, or Location of Death: Edgemere

4c. County of Death: Baltimore

Funeral Director

5. Sociel Security Number: 219-56-5051

6. Sex: 1☐M 2☒F

7. Age *(In yrs. last birthday)*: 64 Yrs.

If Under 1 Yeer: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: July 3, 1936

9. Birthplece *(Stete or Foreign Country)*: Va.

Usuel Residence of Decedent

10a. Stete: Md

10b. County: Baltimore

10c. City, Town or Location: Edgemere

10d. Inside City Limits: 1☐Yes 2☒No

10e. Streel and Number: 2310 Lodge Farm Rd.

10f. Zip Code: 21219

10g. Citizen of Whet Country?: USA

11. Meritel Status: 1☐Never Merried 2☐Married 3☐Widowed 4☒Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - Americen Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Eduction *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 7 yrs. / College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: Own Home

17. Fether's Neme *(First, Middle, Last)*: Samuel Lewis Scuggs

18. Mother's Neme *(First, Middle, Maiden Sumeme)*: Annie V. Brown

19e. Informent's Name/Reletionship *(Type, Print)*: Harold Mc Ginnis son

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 2310 Lodge Farm Rd. Edgemere, Md. 21219

20a. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removel from Slate 4☐Donetion 5☐Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other place)*: Holly Hill Mem. Gard

Dete: Feb. 12 2001

20c. Location - City or Town, Stete: Middle River, Md.

21. Signeture of Funeral Service Licensee: Anthony C. Connelly

22. Neme end Address of Fecility: Connelly Funeral Home of Dundalk, P.A. 7110 Sollers POint Rd. Dundalk, Md. 21222

Physician /Medical Examiner

23a. Pert I. Enter the diseese or complications thet caused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory arrest, shock, or heert feilure. List only one cause on eech line.

Approximete Interval Between Onset end Death

Immediete Ceuse (Finel diseese or condition resulting in deeth)

e. Terminal COPD (chronic

Due to (or es a consequence of):

b. obstructive pulmonary Disease)

Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Last

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

HBP

GERD

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Wes en eutopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings aveilable prior to completion of ceuse of death? 1☐Yes 2☐No

25. Wes cese referred to medicel examiner? 1☐Yes 2☒No

26. Plece of Deeth *(Check only one)*: Hospitel: 1☐Inpetient 2☐ER/Outpetient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*

27. Manner of Deeth: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending invesligation 6☐Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑**Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐**Medical Examiner**: On the basis of exemineticn end/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) and menner steted.

29b. Signeture and title of certifier: Ronald Attanasio MD

29c. License number: D28097

29d. Dete signed *(Month, Dey, Yeer)*: 2/12/01

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print): RONALD ATTANASIO 1576 MERRITT BLVD, Balt. Md. 21227

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: FEB 14 2001

32. Registrer's Signeture: James B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04219

FEBUARY 10, 2001 2:09 a.m.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

JAMES WOMER

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
James	H.	Womer Jr.	February 10, 2001	2:09 am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Stella Maris Hospice - Towson	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-05-5035	1 [X] M 2 [ ] F	80 Yrs.			Sept. 7, 1920	Pa.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Baltimore	Dundalk	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6513 Detroit Ave.	21222	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12 Yrs.	2 Yrs.	Supervisor	Steel

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
James Womer Sr.	Helen K. Wright

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
James H. Womer III son	1902 Towson Ave. Dundalk,Md. 21222

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Bayview Crematory	Feb 13, 2001	Baltimore City

21. Signature of Funeral Service Licensee: Anthony C. Connelly

22. Name and Address of Facility: Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk,Md. 21222

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. LUNG CANCER
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) HOSPICE

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D43725	2/13/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 14 2001	Donna L. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04220

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Barbara Jean Tucker Weems

2. Dete of Death: Month Feb, Day 6, Yeer 2001

3. Time of Death: 7:20 PM

4e. Facility Neme (If not institution, give street end number): 727 N. Kenwood Ave.

4b. City, Town, or Location of Deeth: Baltimore

4c. County of Deeth: N/A

Funeral Director

5. Sociel Security Number: 213-30-3245

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. lest birthday): 66 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): 1/18/35

9. Birthplace (State or Foreign Country): Baltimore, Md.

Usuel Residence of Decedent

10a. State: Md.

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 727 N. Kenwood Ave.

10f. Zip Code: 21205

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanical

16b. Kind of Business/Industry: Copper Co.

17. Fether's Neme (First, Middle, Last): Melvin R. Tucker

18. Mother's Name (First, Middle, Meiden Surneme): Willama Tucker

19a. Informant's Neme/Relationship (Type, Print): Tina Wright

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 727 N. Kenwood Ave, Baltimore, Md. 21205

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other place): Garrison Forest Cem. Date: 2/13/01

20c. Locetion - City or Town, State: Owings Mills, Md.

21. Signeture of Funerel Service Licensee: Lloyd M. Estep

22. Name and Address of Fecility: Estep Brothers Funeral Ser, P.A. 1300 Eutaw Place, Baltimore, Md. 21217

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complications thet ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

		Approximete Intervel Between Onset end Death
Immediate Ceuse (Finel diseese or condition resulting in death) e.	Stroke, thrombotic	1 day
Due to (or es a consequenca of):		
Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest b.	Cerebrovascular disease	Years
Due to (or es a consequenca of):		
c.	Hypertension	Years
Due to (or es e consequence of):		
d.		

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DIABETES MELLITUS; CARCINOID of Small Bowel

23b. Did tobacco use contribute to the cauea of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residenca 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined

28e. Dete of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier: Evangelos C. Lignos MD

29c. License number: D19589

29d. Date signed (Month, Day, Year): 2-8-01

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): EVANGELOS C. LIGNOS 7801 YORK Rd TOWSON MD 21204

State Registrar

31. Dete filed (Month, Day, Year): FEB 14 2001

32. Registrer's Signeture: D. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 72 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, pege 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04221

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Ernest Williams
2. Date of Death: Month February, Day 11, Year 2001
3. Time of Death: 10:10 AM
4a. Facility Name (If not institution, give street end number): Oak Crest Village - Care Center
4b. City, Town, or Location of Death: Parkville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 224-60-6400
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): July 25, 1912
9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8810 Walther Blvd.
10f. Zip Code: 21234
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII Korea
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): personnel management
16b. Kind of Business/Industry: U. S. Civil Service Commission

17. Father's Name (First, Middle, Last): William E. Williams, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Mary Martha Pinckney

19a. Informant's Name/Relationship (Type, Print): Genevieve B Williams/wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8810 Walther Blvd. Parkville, MD 21234

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Crematory
Date: 2/13/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ John D. Mitchell IV
22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Infarction. — 1 hour.
Due to (or as a consequence of):
b. Atherosclerotic Cardiovascular Disease — years.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia, Hypertension.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Susan G Warner
29c. License number: D34941
29d. Date signed (Month, Day, Year): Feb. 12, 2001
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Susan G. Warner MD 8800 Walther Blvd Parkville, Md 21234.

State Registrar

31. Date filed (Month, Day, Year): FEB 14 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

William E. Williams 03-11-01 1010am

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 04222

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frances Young
2. Date of Death (Month, Day, Year): Feb. 10, 2001
3. Time of Death: 11:20am
4a. Facility Name (If not institution, give street and number): Harford Gardens Nursing Home
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 220-22-7039
6. Sex: 1☐ M XX F
7. Age (In yrs. last birthday): 86 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 01-15-15
9. Birthplace (State or Foreign Country): SC

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: XX 1☐ Yes 2☐ No
10e. Street and Number: 917 N. Washington Street
10f. Zip Code: 21205
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married XX 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): High School
College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Factory worker
16b. Kind of Business/Industry: Factory

17. Father's Name (First, Middle, Last): George Hinton
18. Mother's Name (First, Middle, Maiden Surname): Nancy Hinton

19a. Informant's Name/Relationship (Type, Print): Wade Young
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 827 Smoke Tree Road Baltimore, Maryland 21208

20a. Method of Disposition: XX 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): King Mem. Pk. Cemetery
Date: 02-15-2001
20c. Location - City or Town, State: Randallstown MD

21. Signature of Funeral Service Licensee: Joseph L. Walter Jr
22. Name and Address of Facility: Baltimore, Maryland 21202
WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Atherosclerotic Cardiovascular Disease

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Date of Injury (Month, Day, Year): N/A
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Harold Bob MD
29c. License number: D15872
29d. Date signed (Month, Day, Year): Feb 13 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Harold Bob MD 25 Main Street 21136

State Registrar

31. Date filed (Month, Day, Year): FEB 14 2001
32. Registrar's Signature: Jeanne G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04223

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Donald Gerald Yost
2. Date of Death (Month, Day, Year): February 10, 2001
3. Time of Death: 10:15 PM
4a. Facility Name (If not institution, give street and number): 8222 Gray Haven Road
4b. City, Town, or Location of Death: Dundalk
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-30-6001
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 66 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 20, 1934
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8222 Gray Haven Road
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: 1953-56
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years; College (1-4or 5+): 2 Years
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Program Director
16b. Kind of Business/Industry: Industrial Technology

17. Father's Name (First, Middle, Last): Frank A. Yost
18. Mother's Name (First, Middle, Maiden Surname): Helen Nitka

19a. Informant's Name/Relationship (Type, Print): Mrs. Eleanor M. Yost (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8222 Gray Haven Road Dundalk, Maryland 21222

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) Entombment
20b. Place of Disposition (Name of cemetery, crematory or other place): Holly Hill Mem. Gdns.
Date: 2/14/2001
20c. Location - City or Town, State: Middle River, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Squamous Cell Cancer of Lung — 14 weeks
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Janet Cooper MD
29c. License number: D46118
29d. Date signed (Month, Day, Year): Feb 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JANET COOPER MD 1447 York Rd Lutherville MD 21093

State Registrar

31. Date filed (Month, Day, Year): FEB 14 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04224

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RAYMOND ZUBROWSKI
2. Dete of Death: Month February Dey 11th Yeer 2001
3. Time of Death: 9:21 pm
4e Facility Neme (If not Institution, give street end number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Deeth:

Funeral Director

5. Social Security Number: 213-28-8867
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. lest birthdey): 70 Yrs. — If Under 1 Yeer: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): January 24, 1931
9. Birthplece (Stete or Foreign Country): Md

Usuel Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street end Number: 6602 Danville Ave.
10f. Zip Code: 21224
10g. Citizen of Whet Country?: USA

11. Maritel Status: 1 ☐ Never Married 2 ☒ Merried 3 ☐ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - Americen Indien, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grede completed): Elementery/Secondery (0-12): 12 yrs. College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Deputy Clerk
16b. Kind of Business/Industry: State of Maryland
17. Fether's Neme (First, Middle, Last): Francis Zubrowski
18. Mother's Name (First, Middle, Maiden Sumeme): Regina Fryza
19a. Informant's Neme/Reletionship (Type, Print): Elaine Zubrowski wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 6602 Danville Ave, Dundalk, Md. 21224
20e. Method of Disposition: 1 ☒ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other place): St. Stanislaus Cemetery
Dete: Feb. 15, 2001
20c. Location - City or Town, Stete: Baltimore, Md.
21. Signeture of Funeral Service Licensee: Anthony C. Connelly
22. Neme and Address of Feciliy: Connelly Funeral Home of Dundalk, P.A. 7110 Sollers POint Rd. Dundalk, Md. 21222

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heart failure. List only one cause on eech line.

		Approximete Interval Between Onset end Deeth
Immediete Ceuse (Finel diseese or condition resulting in deeth) a.	myocardial infarction	3 days
Due to (or es e consequence of):	coronary artery disease	years
Sequentielly list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest b.		
Due to (or es e consequence of):		
c.		
Due to (or es e consequence of):		
d.		

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.: diabetes

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings eveilable prior to completion of ceuse of deeth? 1 ☐ Yes 2 ☐ No

25. Wes cese referred to medicel exeminer? 1 ☐ Yes 2 ☒ No

26. Piece of Deeth (Check only one): Hospitel: 1 ☒ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Menner of Deeth: 1 ☒ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigetion 6 ☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) end manner es steted. 2 ☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: Singhal
29c. License number: RES-000
29d. Date signed (Month, Dey, Yeer): February 11th, 2001

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print): Sunil Singhal 600 North Wolfe Street Baltimore, Maryland 21287

State Registrar

31. Dete filed (Month, Dey, Yeer): FEB 14 2001
32. Registrer's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04225

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EARL RAY ARTHUR

2. Date of Death: Month 01 Day 26 Year 2001

3. Time of Death: 4:20 P.M

4a. Facility Name *(If not institution, give street and number)*: University of Maryland Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 236-22-8029

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 12/31/21

9. Birthplace *(State or Foreign Country)*: WEST VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: CARROLL

10c. City, Town or Location: HAMPSTEAD

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4424 BLACK ROCK ROAD

10f. Zip Code: 21074

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 4 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: COAL MINER

16b. Kind of Business/Industry: MINING

17. Father's Name *(First, Middle, Last)*: DOCK EVANS ARTHUR

18. Mother's Name *(First, Middle, Maiden Surname)*: CORA BELL REED

19a. Informant's Name/Relationship *(Type, Print)*: ELIZABETH ARTHUR, WIFE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4424 BLACK ROCK RD, APT 7,HAMPSTEAD, MD 21074

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MANCHESTER BAPTIST CEM

Date: 01/31 2001

20c. Location - City or Town, State: MANCHESTER. MD

21. Signature of Funeral Service Licensee: Steven W Eline M00723

22. Name and Address of Facility: ELINE FUNERAL HOME 934 SOUTH MAIN ST, HAMPSTEAD, MD 21074

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Chronic Lung Disease — 44 years

Due to (or as a consequence of):

b. Acute Renal Failure — 1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rosalie Naglieri MD.

29c. License number: P13138

29d. Date signed *(Month, Day, Year)*: 01/26/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rosalie Naglieri, 10 N. Greene Street, Baltimore, MD 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 30 2001

32. Registrar's Signature: Jenna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04226

Pace Brooks 1-21-01 6:45pm

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Pace R. Brooks
2. Date of Death Month Day Year: Jan. 21, 2001
3. Time of Death: 6:45 PM
4a. Facility Name (If not institution, give street and number): Gilchrist Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-07-2832
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 96 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jul 12, 1904
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Eldersburg
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1825 # G Vincenza Dr.
10f. Zip Code: 21784
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bethlehem Steel
16b. Kind of Business/Industry: Wire Dept.

17. Father's Name (First, Middle, Last): Samuel Brooks
18. Mother's Name (First, Middle, Maiden Surname): Claire Harper

19a. Informant's Name/Relationship (Type, Print): Gladys Brooks(Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1825 #G Vincenza Dr. Eldersburg, MD 21784

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Carroll Cremation
Date: Jan. 24, 2001
20c. Location - City or Town, State: Hampstead, MD

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Burrier-Queen Funeral Directors, P.A. 1212 West Old Liberty Rd. Winfield, MD 21784

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Rectal cancer	months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D0051926
29d. Date signed (Month, Day, Year): 1/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Helen M. Gordon MD 6565 N. Charles St, Baltimore MD 21204

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001
32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 26 per Physician 01/30/2001, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04227

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
STUART LUTHER BISH	JAN. 27, 2001	6:45 PM.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
15 S. CHURCH ST.	WESTMINSTER	CARROLL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-28-4009	1☒ M 2☐ F	68 Yrs.			8/11/1932	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	CARROLL	WESTMINSTER	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
15 S. CHURCH ST.	21157	USA

11. Maritat Status	12. Wes Decedent Ever in U.S. Armed Forcas?	13. Wes Dacedant of Hispanic Origin? (Specify Yes or No- It Yas, specify Cuben, Mexican, Puerto Rican, etc.)	14. Rece - Amarican Indien, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates: 1953 1955	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		OFFICE WORKER	BOOK DISTRIBUTOR

17. Fether's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
PAUL NEWCOMER BISH	MARCELLA ALTLAND

19e. Informant's Name/Reletionship (Type, Print)	19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)
JANET N. BISH -WIFE	15 S. CHURCH ST., WESTMINSTER, MD. 21157

20e. Method of Disposition	20b. Place of Disposition (Neme of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, State
1☒ Burial 2☐ Cremetion 3☐ Removal from Stata 4☐ Donetion 5☐ Other (Specify)	TRINITY LUTHERAN CEM.	1/31/01	SMALLWOOD, MD.

21. Signature of Funeral Service Licensee: R Lamy Nightinger

22. Name end Address of Fecility: FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications (bet caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in death) a.	Liver fadure	1998
Due to (or es e consequence of): b.	Cirrhosis of the Liver	1996
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last — Due to (or as a consequence of): c.	Nodular Sclerosin, Hodgkins Dis	1989
Dua to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

- IDDM -

23b. Did tobacco uaa contributa to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed?	24b. Were eutopsy tindings eveileble prior to completion of causa of death?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Wes case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ ~~Other (Specify)~~

27. Manner of Death	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)			28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner steted.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
Dean H. Griffin	D04278	01/29/01

30. Name end address of person who completed cause ot death (Item 23e) (Type, Print): DEAN H. GRIFFIN MD 19 RIDGE RD., WESTMINSTER, MD. 21157

State Registrar

31. Dete filed (Month, Day, Year)	32. Registrer's Signeture
JAN 30 2001	Jeanne G Sparks

Baltimore, Maryland 21215-0020

permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04228

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HAZEL MARIE BOWLING

2. Date of Death — Month: Feb Day: 02 Year: 2001

3. Time of Death: 9:55 AM

4a. Facility Name *(If not institution, give street and number)*: Civista Medical Center

4b. City, Town, or Location of Death: LaPlata

4c. County of Death: Charles

Funeral Director

5. Social Security Number: 197-22-9225

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 70 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: April 5,1930

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: MD

10b. County: Charles

10c. City, Town or Location: La Plata

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 303 Prospect Street

10f. Zip Code: 20646

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 12

College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Registered Nurse

16b. Kind of Business/Industry: Hospital

17. Father's Name *(First, Middle, Last)*: Lawrence G. Heller

18. Mother's Name *(First, Middle, Maiden Surname)*: Hazel M. Baker Heller

19a. Informant's Name/Relationship *(Type, Print)*: Deborah Muth/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 80 La Plata,MD 20646

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Trinity Memorial Gar. Date: 2/5/01

20c. Location - City or Town, State: Waldorf,Maryland

21. Signature of Funeral Service Licensee: David C. Echols M00645

22. Name and Address of Facility: AREHART-ECHOLS FUNERAL HOME,P.A. P.O. BOX 567 LA PLATA,MD. 20646

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. BILATERAL PNEUMOTHORAX	5 DAYS
Due to (or as a consequence of):	b. SEVERE ASTHMA	MANY YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. SEPSIS	5 DAYS
Due to (or as a consequence of):	d. DYSRRYTHMIA	MANY YEARS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

GASTRITIS

OSTEOPOROSIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kevin Lee

29c. License number: D-054804

29d. Date signed *(Month, Day, Year)*: 02/02/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kevin K Lee,MD 7-C Post Office Road Waldorf,MD 20602

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 05 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

BOWLING, HAZEL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04229

Eugene Bochniak

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eugene J. Bochniak, Sr.
2. Date of Death — Month: JANUARY Day: 30 Year: 2001
3. Time of Death: 3:50 P.M.
4a. Facility Name (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL CENTER
4b. City, Town, or Location of Death: ROSEDALE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 215-34-8129
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 63 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 25, 1937
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 9900 Walther Blvd.
10f. Zip Code: 21234
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Exxon Dealer
16b. Kind of Business/Industry: Self-Employed Gasoline Dealer

17. Father's Name (First, Middle, Last): Edward Bochniak
18. Mother's Name (First, Middle, Maiden Surname): Veronica Niziolek

19a. Informant's Name/Relationship (Type, Print): Mr. John K. Bochniak (son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 502 Copeland Road, Fallston, MD 21047

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Green Mount Crematory
Date: 2/3/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Christina L. David
22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. SUBARACHNOID HEMORRHAGE
Due to (or as a consequence of):
b. STATUS POST FALL

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year): 01 27 01
28b. Time of Injury: 9:00 P M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: FELT WEAK AND FELL HITTING HEAD
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): HOME - ASSISTED LIVING FACILITY
28f. Location (Street and Number or Rural Route Number, City or Town, State): 9900 WALTHER BLVD BALTIMORE, MD 21234

29a. Certifier (Check only one): [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [illegible] MD Dr. MILITELLO 1/31/01 Deputy
29c. License number: D 203349
29d. Date signed (Month, Day, Year): JANUARY 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VIRGANEYCE LYONS-BOUDREAUX, MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

State Registrar

31. Date filed (Month, Day, Year): FEB 1 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Eugene Bochniak

OAT

12

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #5 PER F.H. G793 3-2-01 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04230

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Angel Faith Bowens

2. Date of Death (Month, Day, Year): JANUARY 29 2001

3. Time of Death: 14:45

4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death:

Funeral Director

5. Social Security Number: NONE

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min. 10

8. Date of Birth (Month, Day, Year): Jan. 29 2001

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Caroline

10c. City, Town or Location: Federalsburg

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 638 Liberty Road

10f. Zip Code: 21632

10g. Citizen of What Country?: U.S.A.

11. Meritel Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Orlgin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: white

15. Decadent's Education (Specify only highest grade completed)
Elementery/Secondery (0-12) / College (1-4or 5+)

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

17. Father's Neme (First, Middle, Last): Levin Lester Bowens Jr.

18. Mother's Name (First, Middle, Maiden Surname): Melissa Lynn Mowbray

19a. Informent's Neme/Reletionship (Type, Print): Melissa L. Mowbray - mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 638 Liberty Rd., Federalsburg, MD 21632

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): East New Market cemetery

Dete: 2-3

20c. Location - City or Town, Stete: East New Market, MD

21. Signature of Funeral Service Licensee: Thomas J. Sowers

22. Neme end Address of Facility: Thomas Funeral Home, PA 700 Locust St., Cambridge, MD 21613

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Interval Between Onset end Death

Immediate Cause (Finel diseese or condition resulting in deeth)
e. Congenital Anomaly — 40 weeks

Due to (or es a consequence of):
b. Fetal Encephalocele (large) — 40 weeks

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest

Due to (or es e consequence of):
c.

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
status post Spontaneous vaginal delivery

23b. Dfd tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Deeth (Check only one)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) end menner es steted. 2☐ **Medicef Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end pleca, and due to the ceuse(s) end manner steted.

29b. Signeture end title of certifier: Melissa W Costello

29c. License number: RES-000

29d. Date signed (Month, Day, Year): January 29, 2001

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): MELISSA W. COSTELLO JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21287

State Registrar

31. Dete filed (Month, Dey, Yeer): FEB 01 2001

32. Registrer's Signeture: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04231

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HELEN CRISWELL
2. Date of Death: Month JANUARY Day 28TH Year 2001
3. Time of Death: 5:00 PM
4a. Facility Name *(If not institution, give street and number)*: NORTHWEST HOSPITAL CENTER
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE.

Funeral Director

5. Social Security Number: 219-60-5970
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 12/28/1918
9. Birthplace *(State or Foreign Country)*: Baltimore, Md.

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Reisterstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 217 Highmeadow Road
10f. Zip Code: 21136
10g. Citizen of What Country?: U.S.A.

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Homemaking

17. Fether's Neme *(First, Middle, Last)*: George Gregory Bryan
18. Mother's Name *(First, Middle, Maiden Surneme)*: Anne Lee Swain

19a. Informent's Neme/Reletionship *(Type, Print)*: James G. Criswell - son
19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 217 Highmeadow Rd. Reisterstown, Md. 21136

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Evergreen Mem. Gardens | Date: Feb. 1, 2001
20c. Location - City or Town, State: Finksburg, Md.

21. Signature of Funerel Service Licensee: Justin R. Eckhardt
22. Name and Address of Fecility: Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd. Owings Mills, Md. 21117

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert feilure. List only one cause on eech line. | Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Finel diseese or condition resulting in deeth)
a. CONGESTIVE HEART FAILURE
Due to (or es e consequence of):
b. DIASTOLIC DYSFUNCTION.

Sequentially list conditions, if any, leeding to Immediete cause. Enter Underlying Ceuse (Disease or injury thet Initieted events resulting in death) Last
Due to (or es a consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No
26. Piece of Deeth *(Check only one)*: Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the besis of exemineticn end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner steted.
29b. Signature end title of certifier: A. Harish
29c. License number: D42723
29d. Date signed *(Month, Day, Year)*: JANUARY 28TH 2001
30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): AVVERAHALLI M HARISH NORTHWEST HOSPITAL CENTER 5401 OLD COURT ROAD MD 21133

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 30 2001
32. Registrer's Signeture: Geneva G Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04232

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Burgess Condon

2. Data of Death — Month: Jan. Day: 24 Year: 2001

3. Time of Death: 1:42 AM

4a. Facility Name (If not institution, give street and number): Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-05-2710

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 93 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Oct. 26 1907

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Garrett

10c. City, Town or Location: Accident

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 354 Highland Ave.

10f. Zip Code: 21520

10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 9th grade — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Forman

16b. Kind of Business/Industry: Baltimore Gas and Electric

17. Father's Name (First, Middle, Last): Burgess Condon

18. Mother's Name (First, Middle, Maiden Surname): Annie Amelia Barnes

19a. Informant's Name/Relationship (Type, Print): Virginia Condon Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): PO Box 35 Accident, MD 21520

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Taylorsville Cemetery

Date: Jan. 27, 2001

20c. Location - City or Town, State: Taylorsville,MD

21. Signature of Funeral Service Licensee: Jana B Covey

22. Name and Address of Facility: Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Myocardial infarction — 2 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic Renal Failure

23b. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one) — Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mark Sagin

29c. License number: D 35481

29d. Date signed (Month, Day, Year): January 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Mark Sagin Memorial Hospital Suite 400 Cumberland, MD 21502

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04233

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ethel Louise Conant

2. Date of Death — Month: January; Day: 27; Year: 2001

3. Time of Death: 0150

4a. Facility Name *(If not institution, give street and number)*: The Kent & Queen Anne's Hospital Inc.

4b. City, Town, or Location of Death: Chestertown

4c. County of Death: Kent

Funeral Director

5. Social Security Number: 222-09-0445

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 79 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 27, 1921

9. Birthplace *(State or Foreign Country)*: Delaware

Usual Residence of Decedent

10a. State: Maryland

10b. County: Queen Anne's

10c. City, Town or Location: Crumpton

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1 Elizabeth Lane

10f. Zip Code: 21628

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 yrs; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Domestic

17. Father's Name *(First, Middle, Last)*: Mathew Oldham

18. Mother's Name *(First, Middle, Maiden Surname)*: Alice Hamilton

19a. Informant's Name/Relationship *(Type, Print)*: Alice M. Pearson Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1 Vivian Court Newark, De. 19702

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Crumpton Cemetery

Date: 1/31/01

20c. Location - City or Town, State: Crumpton, Md.

21. Signature of Funeral Service Licensee: Fellows

22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home 370 W. Cypress St. Millington, Md. 21651

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MESENTERIC ISCHEMIA — 24 HOURS

Due to (or as a consequence of):

b. DIABETES MELLITUS — 20 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John C. Seymour MD

29c. License number: D-0013824

29d. Date signed *(Month, Day, Year)*: 1-29-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John C. Seymour, 122 Speer Road, Chestertown, MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 30 2001

32. Registrar's Signature: Donna P. Goode

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

ADMEND ITEM: #13
AMEND ITEM: #14 PER F.H. G792 2-28-01 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04234

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jeffrey David Chase
2. Date of Death (Month, Day, Year): January 24, 2001
3. Time of Death: 5:40 P.M.
4a. Facility Name (If not institution, give street and number): 200 Grays Road
4b. City, Town, or Location of Death: Harwood
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 227-66-0470
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 52 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 14, 1948
9. Birthplace (State or Foreign Country): Georgia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Harwood
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 200 Grays Road
10f. Zip Code: 20776
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: X
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): X | College (1-4or 5+): 4 yrs.
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accountant
16b. Kind of Business/Industry: FDIC Federal Government

17. Father's Name (First, Middle, Last): Robert E. Chase
18. Mother's Name (First, Middle, Maiden Surname): Beatrice Sargent

19a. Informant's Name/Relationship (Type, Print): Lynn G. Chase/ Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 200 Grays Road Harwood, Maryland 20776

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Grantham Family Cem. Date: 1-27-01
20c. Location - City or Town, State: Grantham, NC

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. METASTATIC COLON CANCER	4 MONTHS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: [signature] Peter R Graze MD
29c. License number: D16364
29d. Date signed (Month, Day, Year): 01/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PETER R GRAZE MD 90 BESTGATE RD 300 ANNAPOLIS MD 21401

State Registrar

31. Date filed (Month, Day, Year): JAN 2 6 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ADMEND ITEM: #7 PER F.H. G794 4-21-01 WR

Certificate of Death

Reg. No. 2001 04235

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Mamie Catherine Carroll
2. Dete of Deeth: Month January Dey 21 Year 2001
3. Time of Deeth: 3:50pm
4a. Facility Neme (If not institution, give street end number): Mariner Health of Greater Laurel
4b. City, Town, or Locelion of Deeth: Laurel
4c. County of Deeth: Prince George's

Funeral Director

5. Social Security Number: 240-76-8523
6. Sex: 1☐ M 2☐ F XX
7. Age (In yrs. last birthday): 55 ~~45~~ Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dale of Birth (Month, Dey, Yeer): September 7,45
9. Birthplece (State or Foreign Country): North Carolina

Usuel Residence of Decedent

10a. Stete: MD
10b. County: Prince George's
10c. City, Town or Location: Capitol Heights
10d. Inside City Limits: 1☐ Yes 2☐ No XX
10e. Street end Number: 131 Maryland Park Drive
10f. Zip Code: 20743
10g. Citizen of Whet Country?: United States America

11. Meritel Status: 1☒ Never Merried 2☐ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Americen Indian, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Disable
16b. Kind of Business/Industry: Self

17. Fether's Neme (First, Middle, Lest): Bert Carroll
18. Mother's Name (First, Middle, Maiden Surneme): Lottie Mae Outlaw

19a. Informent's Name/Relelionship (Type, Print): Naomie C. Smith - Sister
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 131 Maryland Park Drive; Capitol Heights, MD 20743

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☒ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other place): Maxwell Cemetery
Dete: 1/27/01
20c. Locetion - City or Town, Stete: Rose Hill, N.C.

21. Signeture of Funerel Service Licensee: Glenda Greenan
22. Neme and Address of Feciility: Robert O. Freeman Funeral Services, Inc. 1353 H Street, N.E.; Washington, D.C. 20002

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Finel disease or condition resulting in death)
e. Chronic Obstructive Lung Disease

Due to (or as a consequence of):
Polycythemia Vera

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest
b.
Due to (or es e consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cauee of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveilable prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was cese referred lo medical examiner? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: P Smith MD Attending
29c. License number: D42580
29d. Date signed (Month, Dey, Yeer): 1-23-01

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print): P.S. AUJLA, MD 5632 ANNAPOLIS RD STE#13 Bladensburg, MD 20710

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 24 2001
32. Registrer's Signeture: P. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

P.6.

7-26

5

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04236

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Russell A. Cook, Jr.

2. Data of Death Month Dey Yeer: January 22, 2001

3. Time of Death: 2032

4a Facility Neme *(If not institution, give street and number)*: Upper Chesapeake Medical Campus

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 148-32-3241

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 61 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Year)*: March 19, 1939

9. Birthplece *(State or Foreign Country)*: New Jersey

Usual Rasidance of Decedant

10a. Stete: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street end Number: 510 Greenridge Road

10f. Zip Code: 21015

10g. Citizen of Whet Country?: United States

11. Marital Status: 1 [ ] Never Merried 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yas 2 [X] No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, Whita, atc. *Specify:* White

15. Decedant's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 4 Years; College (1-4or 5+):

16a. Decedant's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Civil Engineer

16b. Kind of Businass/Industry: Cement Company

17. Fether's Name *(First, Middle, Last)*: Russell A. Cook, Sr.

18. Mothar's Name *(First, Middle, Maiden Surname)*: Charlotte Palmroth

19a. Informent's Name/Relationship *(Type, Print)*: Christopher Cook

19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 16020 Pensbury Drive Bowie, Maryland 20716

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Piece of Disposition *(Name of cematary, crematory or other place)*: Greenmount Crematory

Data: 1/24/01

20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signature of Funaral Service Licensee: Amanda Kelly

22. Nama end Address of Facility: Schimunek Funeral Home, Inc. 610 W. Macphail Road Bel Air, Maryland 21014

Physician /Medical Examiner

23a. Part1. Enter tha disaasa, or complications that ceused the deeth. Do not enter tha moda of dying, such as cardiac or raspiretory errest, shock, or heart failure. List only ona causa on aach line.

Approximete Intarval Batween Onset end Deeth

Immediata Causa (Final disaase or condition resulting in deeth)

e. HEPATOCELLULAR FAILURE — 7 days

Dua to (or as a consequance of):

b. ALCOHOLIC LIVER CIRRHOSIS — YEARS

Sequentially list conditions, if any, leeding to immedieta cause. Enter Underlying Cause (Disaase or injury that initieted events resulting in deeth) Last

Due to (or es e consequance of):

c.

Dua to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uss contribute to the causs of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings eveilable prior to completion of ceuse of daath? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yas 2 [X] No

26. Piece of Death *(Chack only ona)*: Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Mannar of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be datarmined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

29a. Cartifier *(Check only one)*: 1 [X] **Certifying Physician**: To tha best of my knowladga, daath occurred at the tima, data end plece, end due to tha ceuse(s) and mannar as statad. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the ceuse(s) end menner steted.

29b. Signature end title of certifier: MAbhyankar MD

29c. Licensa number: D 25027

29d. Date signed *(Month, Day, Year)*: JANUARY 23, 2001

30. Name and address of person who completed causa of daath (Item 23a) (Type, Print): VIJAY M. ABHYANKAR, 2 NORTH AVENUE BEL AIR, MD 21014

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 24 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Albert Russell Cook, Jr

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 8 per F.D. 01/30/2001, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04237

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Welton V. Dorsey
2. Date of Death (Month, Day, Year): Jan. 27, 2001
3. Time of Death: 3:00 PM
4a. Facility Name (If not institution, give street and number): Montgomery County General Hospital
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 213-42-2773
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 56 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 6, 1944 ~~Dec. 6, 1940~~
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Mount Airy
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 1001 Meadowgreen Dr.
10f. Zip Code: 21771
10g. Citizen of Whet Country?: United States
11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1968
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Raca - American Indian, Bleck, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Security Supervisor
16b. Kind of Business/Industry: Montgomery Co. Gov.
17. Father's Name (First, Middle, Last): James Ellsworth Dorsey
18. Mother's Neme (First, Middle, Maiden Surname): Martha Jane Anderson
19a. Informant's Name/Relationship (Type, Print): Darlene King-Dorsey (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1001 Meadowgreen Dr. Mt. Airy, Md 21771
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Placa of Disposition (Neme of cemetery, cremetory or other piece): Friendship Cemetery
Date: 1/31/2001
20c. Location - City or Town, State: Damascus, MD
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Burrier-Queen Funeral Directors, P.A. 1212 West Old Liberty Rd. Winfield, MD 21784

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Final disease or condition resulting in death) a.	Myocardial Infarction	1 hour
Due to (or as a consequence of):	Coronary Atherosclerosis	5 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Due to (or as a consequenca of):	
c.	Due to (or as a consequence of):	
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the causa of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was en autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es steted. 2 ☐ **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D0030414
29d. Date signed (Month, Day, Year): JANUARY 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. John Herring 9210 Corporate Blvd. Suite 210 Rockville, Md 20850

State Registrar

31. Date filed (Month, Day, Year): JAN 3 0 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificata be axecuted within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ADMEND ITEM: 4A PER PHY G795 5-4-01 WE

Certificate of Death

Reg. No. 2001 04238

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Josylene Lenna

2. Date of Death: Month 1 Day 21 Year 01

3. Time of Death: 7:20 PM

4a. Facility Name (If not institution, give street and number): 1920 COLONIAL RD. ~~203-LAUREL STREET~~

4b. City, Town, or Location of Death: POCOMOKE

4c. County of Death: WORCESTER

Funeral Director

5. Social Security Number: 220-32-9960

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 7-14-21

9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD. | 10b. County: WORCESTER | 10c. City, Town or Location: POCOMOKE | 10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1920 - COLONIAL ROAD | 10f. Zip Code: 21851 | 10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 6 | College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): POULTRY WORKER

16b. Kind of Business/Industry: P.E.L FACTORY

17. Father's Neme (First, Middle, Last): RAYMOND SCHOOLFIELD

18. Mother's Neme (First, Middle, Maiden Surneme): EMMA MURREL SCHOOLFIELD

19a. Informent's Name/Reletionship (Type, Print): SHARON BENOIT - DAUGHTER

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 712-10th St. Apt 208-POCOMOKE, MD. 21851

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): ST JAMES CEMETARY | Date: 1/27/01

20c. Location - City or Town, State: POCOMOKE, MD.

21. Signature of Funerel Service Licensee: [signature]

22. Name end Address of Facility: BENNIE SMITH F/H 917-W. ISABELLA ST. SALISBURY, MD. 21801

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one ceuse on eech line. | Approximete Intervel Between Onset end Death

Immediate Cause (Final diseese or condition resulting in deeth)
a. Coronian Arrest — MINS
Due to (or es e consequence of):
b. Congestive Heart Failure — YRS

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Lest
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Adeno carcinoma Stomach, Status Post Aortic Valve Replacement

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted. 2☐ Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the cause(s) and menner stated.

29b. Signeture end title of certifier: [signature] MD

29c. License number: D10658

29d. Date signed (Month, Day, Year): 1/23/01

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): DONALD M. WOOD, MD - 400 Eastern Shore Drive, Salisbury Md 21801

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 24 2001

32. Registrer's Signeture: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04239

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LUCIEN ARTHUR DANIS
2. Date of Death (Month, Day, Year): JAN 19 2001
3. Time of Death: 10:48 PM
4a. Facility Name (If not institution, give street and number): NATIONAL NAVAL MEDICAL CENTER
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 009-05-4146
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 11, 1921
9. Birthplace (State or Foreign Country): Vermont

Usual Residence of Decedent

10a. State: Virginia
10b. County: Fairfax
10c. City, Town or Location: Fairfax
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 9916 Duncan Street
10f. Zip Code: 22031
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sergeant
16b. Kind of Business/Industry: U.S. Army

17. Father's Name (First, Middle, Last): Joseph Danis
18. Mother's Name (First, Middle, Maiden Surname): Mary Compagnon

19a. Informant's Name/Relationship (Type, Print): Dorothea Danis / Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9916 Duncan Street, Fairfax, Virginia 22031

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington National Cem. Date: 02/01/01
20c. Location - City or Town, Stete: Arlington, Virginia

21. Signature of Funeral Service Licensee: Alan J. Donnell
22. Name and Address of Facility: Everly Funeral Home, 10565 Main Street, Fairfax, Virginia 22030

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ASYSTOLE

Due to (or as e consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last:
b. CANDIDEMIA
Due to (or as a consequenca of):
c.
Due to (or as a consequenca of):
d.

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated. 2☐ **Medical Exeminer:** On the beels of examination end/or investigetion, in my opinion, deeth occurred at the time, date and piece, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: D. L. Gramins MD
29c. License number: G-79711 (CA)
29d. Date signed (Month, Day, Yeer): 01/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): D.L.GRAMINS, LCDR, MC, USNR, NATIONAL NAVAL MEDICAL CENTER, BETHESDA MD 20889-5600

State Registrar

31. Date filed (Month, Day, Year): JAN 23 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Mont. GF

12

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04240

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dalton Phillip Davis
2. Data of Death Month / Day / Year: January 25, 2001
3. Time of Death: 05:54
4a. Facility Name *(If not Institution, give street and number)*: Union Hospital
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 222-90-0147
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 2 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: July 18, 1998
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residenca of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Elkton
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 13 Thyme Street
10f. Zip Code: 21921
10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedant Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Raca - American Indian, Black, Whita, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 0 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*:
16b. Kind of Business/Industry:

17. Father's Name *(First, Middle, Last)*: William P. Davis, Jr.
18. Mother's Name *(First, Middle, Maiden Surname)*: Elisha Turner

19a. Informant's Name/Relationship *(Type, Print)*: William P. Davis, Jr./Father
19b. Maiting Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13 Thyme Street, Elkton, Maryland 21921

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gilpin Manor Memorial Park
Date: 1/29/01
20c. Location - City or Town, State: Elkton, Maryland

21. Signature of Funaral Sarvice Licensee: Donald S. Hicks
22. Name and Address of Facility: Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921

Physician /Medical Examiner

23a. Part1. Enter the diseese, or compticetions that caused the death. Do not enter the mode ot dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final diseasa or condition resulting in deeth): a. Kawasaki's Disease — 4 months

Due to (or as e consequence of):

Sequentiatly tist conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequenca of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

23b. Did tobacco usa contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings available prior to complation of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case refarred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpetient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residenca 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and placa, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: H. Farkas, MD
29c. License number: D15314
29d. Date signed *(Month, Day, Year)*: January 25, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): H Farkas, MD Union Hospital, Elkton, MD 21921

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 30 2001
32. Registrar's Signatura: Sandra D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04241

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: John Clarence Edwards
2. Date of Deeth (Month, Day, Yeer): January 30, 2001
3. Time of Deeth: 8:25a.m.
4a. Feciity Name *(If not institution, give street and number)*: Corsica Hills Nursing Home
4b. City, Town, or Location of Deeth: Centreville
4c. County of Deeth: Queen Anne's

Funeral Director

5. Sociel Security Number: 218-34-9634
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 94 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Yeer)*: March 24, 1906
9. Birthplace *(Stete or Foreign Country)*: Rock Hall, MD

Usual Residence of Decedent

10a. State: Maryland
10b. County: Kent
10c. City, Town or Location: Rock Hall
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 22874 McKinleyville Road
10f. Zip Code: 21661
10g. Citizen of Whet Country?: USA
11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Bleck, White, etc. *Specify:* White
15. Decedent's Eduestion *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Waterman
16b. Kind of Business/Industry: Seafood
17. Fether's Name *(First, Middle, Lest)*: Clarence Fisher Edwards
18. Mother's Name *(First, Middle, Maiden Surname)*: Mattie Virginia Dolan
19a. Informent's Name/Relationship *(Type, Print)*: John Daniel Edwards
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 5088 Edwards Lane, Rock Hall, Maryland 21661
20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Wesley Chapel Cemetery
Date: 2/3/2001
20c. Location - City or Town, Stete: Rock Hall, Maryland
21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name end Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximate Intervel Between Onset end Death

Immediate Ceuse (Final diseese or condition resulting in deeth)
e. Pneumonia
Due to (or es e consequence of):

Sequentially list conditions, if eny, feeding to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in deeth) Last
b.
Due to (or es e consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.: Chronic Interstitial colitis

23b. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Piece of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and manner es steted. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(s) and menner steted.

29b. Signeture end title of certifier: ▶ [signature]
29c. License number: 032036
29d. Date signed *(Month, Dey, Year)*: 1/30/2001

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print): Gay J. Sprowes 2108 P. Ponds Drive Chester MD 21619

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 01 2001
32. Registrar's Signature: [signature]

4

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylend Department of Health end Mentel Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the **Hospital or Attending Physician:** The law requires that the death certificete be executed within 24 hours after deeth.
To the **Funeral Director:** After this certificete hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04242

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen Elizabeth Foster

2. Data of Death Month: Jan Day: 29 Year: 2001

3. Time of Death: 1:00 pm.

4a. Facility Name *(If not Institution, give street and number)*: 501 Enola Rd.

4b. City, Town, or Location of Death: Pikesville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-14-4445

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 77 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Feb. 8, 1923

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Pikesville

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 501 Enola Road

10f. Zip Coda: 21208

10g. Citizan of What Country?: U.S.A.

11. Marital Stetus: 1☐ Nevar Married 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yes, Giva Yaar or Datas:

13. Wes Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*

14. Race - Amarican Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): 12 / Collega (1-4or 5+): +2

16a. Decedant's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT usa retired)*: Self-employed

16b. Kind of Businass/Industry: Antique dealer

17. Fathar's Name *(First, Middle, Last)*: George Smith

18. Mother's Nama *(First, Middla, Maidan Surnama)*: Annie Irene Wolfendon

19a. Informant's Name/Ralationship *(Type, Print)*: Bradley T. Foster - son

19b. Mailing Address *(Straat and Number or Rural Routa Number, City or Town, State, Zip Code)*: 501 Enola Rd. Pikesville, Md. 21208

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cematery, crametory or othar placa)*: Druid Ridge Cemetery

Data: Feb. 2, 2001

20c. Location - City or Town, State: Pikesville, Md.

21. Signatura of Funaral Sarvice Licensee: Austin R Dunbar

22. Name end Addrass of Facility: Eckhardt Funeral Chapel P. A. 11605 Reisterstown Rd. Owings Mills, Md. 21117

Physician /Medical Examiner

23a. Part I. Enter tha disaasa, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or haert failura. List only ona cause on each lina.

Approximate Intarval Between Onsat and Deeth

Immediate Cause (Finel diseasa or condition resulting in death)

a. RENAL FAILURE

Dua to (or es a consequence of):

Sequentially list conditions, if any, laading to immedieta cause. Enter Undarlying Ceuse (Diseese or injury that initiated evants resulting in death) Last

b. BACTERIAL ENDOCARDITIS

Dua to (or as a consequence of):

c. Cerebral Vesculer accident CVA

Dua to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Wara autopsy findings available prior to completion of causa of deeth? 1☐ Yas 2☒ No

25. Was case referred to medical examinar? 1☐ Yas 2☒ No

26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA Other: 4☐ Nursing Homa 5☒ Rasidence 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be detarmined

28a. Data of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Piece of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Steta)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at tha time, date and place, end due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date end place, end due to the ceuse(s) and mannar stated.

29b. Signature and title of certifier: Nick Mellis MD ATTEND. PHYSICIAN

29c. License number: D0047762

29d. Data signed *(Month, Day, Year)*: 1/30/01

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Nick Mellis, M.D. 7801 York Road Towson Md 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 3 0 2001

32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04243

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Gertrude Marie Fishack
2. Dete of Deeth — Month: January Day: 25 Year: 2001
3. Time of Death: 12:58 AM
4e. Facility Neme (If not institution, give street and number): Fahrney Keedy Nursing Home
4b. City, Town, or Location of Deeth: Boonsboro
4c. County of Deeth: Washington

Funeral Director

5. Social Security Number: 218-24-9499
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): April 11, 1925
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10e. State: Md.
10b. County: Washington
10c. City, Town or Location: Smithsburg
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: Henrietta St. P.O. Box 78
10f. Zip Code: 21783
10g. Citizen of Whet Country?: U.S.A.
11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White
15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 8 College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Machine Operator
16b. Kind of Business/Industry: Machine Co.
17. Fether's Neme (First, Middle, Last): Rosby M. Poole
18. Mother's Neme (First, Middle, Maiden Surneme): Emma M. Zimmerman
19a. Informent's Name/Reletionship (Type, Print): Jennifer Hammond (Daughter)
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 14123 Clear Spring Rd. Williamsport, Md. 21795
20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Smithsburg Cemetery
Dete: Jan. 28, 2001
20c. Location - City or Town, Stete: Smithsburg, Md.
21. Signature of Funerel Service Licensee: ▶ Dennis L. Davis
22. Name and Address of Feciliity: Davis Funeral Home, 12525 Bradbury Ave. Smithsburg, Md. 21783

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Part 1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediate Ceuse (Finel diseese or condition resulting in death): e. Renal failure — 2mos

Due to (or es e consequence of): b. Chronic Obstructive Pulmonary — 20yrs

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet Initieted events resulting in deeth) Last

Due to (or es e consequence of): c. Hypertension — 20yrs

Due to (or es e consequence of): d. Osteoporosis. — 10yrs.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.: Osteoarthritis, ASCVD, Hypoalbumeinia, Restrictive Lung Disease

23b. Did tobacco use contribute to the cauee of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Phyeician**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and menner es steted. 2☐ **Medical Exeminer**: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and menner stated.

29b. Signature and title of certifier: ▶ Allen Reilly MD

29c. License number: D54749

29d. Date signed (Month, Dey, Yeer): JANUARY 25 2001

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print): 8507 Mapleville Road, Boonsboro, MD 21713-1844

State Registrar

31. Date filed (Month, Dey, Yeer): JAN 26 2001

32. Registrer's Signeture

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires thet tha death certificata be executed within 24 hours after death.

To the Funerel Director: After this certificata has been signed by the attending physician and completely filled in by the funeral director, pega 2 should be detached for use es the burial-transit

Gertrude M. Fishack

DHMH 16 Rev 6/95

MAY 3 1989

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04244

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Evelyn Mae Gibson

2. Data of Death Month: January Day: 29th Year: 2001

3. Time of Death: 10:27 P

4a. Facility Name (If not institution, give street and number): Carroll County General Hospital

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 212-32-2297A

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 87 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): July 8, 1913

9. Birthplace (State or Foraign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 3909 Salem Bottom Road

10f. Zip Coda: 21157

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Nevar Merried 2☐ Merried 3☐ Widowed 4☒ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Race - Amarican Indian, Black, Whita, atc. Specify: Black

15. Decedent's Educetion (Specify only highast grada complated)

Elemantary/Secondary (0-12): 8th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): Homemaker

16b. Kind of Business/Industry: Domestic Worker

17. Fathar's Nama (First, Middla, Last): Marshall Cook

18. Mothar's Nama (First, Middla, Maidan Surnama): Bertie Cross

19a. Informant's Name/Ralationship (Type, Print): Eleanor Costley daughter

19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code): 3909 Salem Bottom Road Westminster, MD 21157

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Nama of camatary, cramatory or othar placa): Fairview UM Ch. Cemetery

Data: Feb.2, 2001

20c. Location - City or Town, Stata: Taylorsville,MD

21. Signature of Funaral Service Licensee: James B Conway

22. Name and Addrass of Facility: Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road, Winfield, MD 21784

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that ceusad the daath. Do not entar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batween Onset and Death

Immediata Causa (Finat disaasa or condition rasulting in death): a. Sepsis — Approximata Intarval: 1 day

Dua to (or as a consequance of):

Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last:

b. Dua to (or as a consequance of):

c. Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying ceusa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to compiation of ceusa of death? 1☐ Yas 2☒ No

25. Was casa rafarred to medical examinar? 1☐ Yas 2☒ No

26. Placa of Death (Check only ona)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify)

27. Manar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ **Certifying Phyaician**: To tha best of my knowladga, death occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner**: On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar statad.

29b. Signeture and title of certifier: MD

29c. License number: D48006

29d. Data signed (Month, Day, Year): January 29th, 2001

30. Name and addrass of person who complated causa of daath (Item 23a) (Type, Print): KOFi BONITEY, 200 Memorial Avenue, Westminster, MD 21157 CARROLL COUNTY GENERAL HOSPITAL

State Registrar

31. Data filed (Month, Day, Year): FEB 01 2001

32. Registrar's Signatura: Jenna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Evelyn M. Gibson

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04245

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joe Goins
2. Dete of Deeth: Month 1 Day 31 Yeer 01
3. Time of Deeth: 02 00
4a. Facility Neme (If not institution, give street end number): Carroll County General Hospital
4b. City, Town, or Location of Deeth: Westminster
4c. County of Deeth: Carroll

Funeral Director

5. Socie! Security Number: 216-16-4765
6. Sex: X M 2 F
7. Age (In yrs. last birthday): 81 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 9 1920
9. Birthplece (Stete or Foreign Country): VA

Usuel Residance of Dacedant

10e. Stete: MD
10b. County: Carroll
10c. City, Town or Location: Westminster
10d. Inside City Limits: 1 Yes 2 X No
10e. Street and Number: 911 Deer Park Road
10f. Zip Code: 21157
10g. Citizen of Whet Country?: USA
11. Meritel Status: 1 Never Married 2 X Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1 X Yes 2 No If Yes, Give Yeer or Dates: 1943 1945
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White
15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 9 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Finish Carpenter
16b. Kind of Business/Industry: Self Employed
17. Father's Name (First, Middle, Last): Charles Goins
18. Mother's Name (First, Middle, Maiden Surneme): Frona Shouse
19a. Informent's Name/Relationship (Type, Print): Carolyn Goins/wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 911 Deer Park Road Westminster, MD 21157
20a. Method of Dispositon: X Burial 2 Cremation 3 Removel from State 4 Donetion 5 Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other place): Garrison Forest — Dete: 2/5/2001
20c. Location - City or Town, State: Garrison, MD
21. Signeture of Funeral Service Licensee: John K. Aydlett
22. Name end Address of Facility: Pritts Funeral Home and Chapel 412 Washington Rd Westminster, MD21157

Physician /Medical Examiner

23a. Pert. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on each line.

		Approximete Intervel Between Onset end Deeth
Immediete Cause (Final disease or condition resulting in deeth) a.	Sepsis	33 hours
Due to (or as e consequence of):		
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Last — b.	Non-Hodgkin's Lymphoma	6 months
Due to (or as e consequence of):		
c.		
Due to (or as a consequance of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: COPD

23b. Did tobecco use contribute to the cauee of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was en eutopsy performed? 1 Yes 2 X No

24b. Were eutopsy findings avelleble prior to completion of cause of deeth? 1 Yes 2 X No

25. Wes case referred to medical examiner? 1 Yes 2 X No

26. Piece of Death (Check only one): Hospital: 1 X Inpatient 2 ER/Outpetient 3 DOA — Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Deeth: 1 X Neturel 2 Accident 3 Suicide 4 Homicide 5 Penging investigation 6 Could not be determined

28e. Date of Injury (Month, Day Yeer)

28b. Time of Injury M

28c. Injury et Work? 1 Yes 2 No

28d. Describe how Injury oocurred

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Streat and Numbar or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1 X Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) and manner stated.

29b. Signeture end title of certifier: Donald R Baker MD

29c. License number: D23719

29d. Date signed (Month, Dey, Yeer): 1/31/01

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): Donald Baker MD, 295 Stoner Ave Westminster 21157 Maryland

State Registrar

31. Date filed (Month, Day, Yaar): FEB 02 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

JOE GOINS

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04246

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Paul D. Gragan

2. Data of Death Month / Dey / Yaar: Feb. 02, 2001

3. Tima of Death: 2:05 AM

4a Facility Nama *(If not institution, give street and number)*: Civista Medical Center

4b. City, Town, or Location of Death: LaPlata

4c. County of Death: CHarles

Funeral Director

5. Social Security Number: 217-32-1984

6. Sex: 1☒ M 2☐ F

7. Aga *(In yrs. last birthday)*: 66 Yrs.

If Undar 1 Yaar: Months / Days

If Undar 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Yaar)*: July 19 1934

9. Birthplece *(State or Foreign Country)*: MD

Usual Residance of Decedent

10a. Stata: MD

10b. County: Charles

10c. City, Town or Location: BelAlton

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 9130 5th Street

10f. Zip Coda: 20611

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☒ Yas 2☐ No If Yas, Give Yaar or Datas: 7/16/57 7/8/59

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Amarican Indian, Black, Whita, atc. *Specify:* White

15. Decadant's Educetion *(Specify only highest grede completed)*: Elamantary/Secondary (0-12): 12 / Collaga (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Mechanic

16b. Kind of Businass/Industry: U.S. Government

17. Fathar's Nama *(First, Middle, Last)*: George Columbus Gragan

18. Mothar's Nama *(First, Middle, Maiden Surneme)*: Anna Elizabeth Gray Gragan

19a. Informant's Name/Ralationship *(Type, Print)*: Linda Gragan/Wife

19b. Mailing Addrass *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9130 5th St. BelAlton,MD 20611

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other plece)*: Brinsfield-Echols F.H.

Data: 2/4/01

20c. Location - City or Town, Stata: Charlotte Hall, MD

21. Signatura of Funaral Sarvice Licensee: David C. Echols MO0945

22. Nama and Address of Facility: Arehart-Echols Funeral Home,P.A. P.O. Box 567 LaPlata,MD 20646

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar the moda of dying, such as cardiac or raspiratory arrast, shock, or haart failure. List only ona ceuse on each line.

Approximata Intarval Batween Onsat and Daath

Immediate Ceuse (Final disaasa or condition resulting in deeth)

a. Hepatic Renal Failure — 2 Weeks

Dua to (or as a consaquance of):

b. Respiratory Collapse and Plural Effusion — 30 Min.

Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Disease or Injury that Initiated evants rasulting in death) Last

Dua to (or as a consequence of):

c. Renal Failure, Diabetes Mellitis Type II — 3 Years

Dua to (or as a consequence of):

d. Cirrhosis of Liver — 3 Years

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco usa contribute to the causa of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Were autopsy findings available prior to complation of ceusa of death? 1☐ Yas 2☑ No

25. Wes cese relarred to medical examinar? 1☐ Yas 2☑ No

26. Place of Deeth *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Mannar of Death: 1☑ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datermined

28a. Data of Injury *(Month, Dey Year)*: —

28b. Tima of Injury: — M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred: —

28e. Plece of Injury - At home, farm, straet, factory, office building, etc. *(Specify)*: —

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Cartifiar *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at tha time, date and place, and dua to tha ceuse(s) and manner as stated. 2☐ **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, deta and place, and dua to tha ceuse(s) and mannar stated.

29b. Signatura and titla of certifier: Arwoody MD

29c. Licansa number: D-11176

29d. Date signed *(Month, Dey, Yaar)*: Feb. 02, 2001

30. Nama and addrass of person who complated ceusa of daath (Item 23a) (Type, Print): Arthur O. Wooddy, M.D. 100 Washington Avenue P.O. Box 430 LaPlata, MD 20646

State Registrar

31. Dete filad *(Month, Day, Yaar)*: FEB 05 2001

32. Registrar's Signature: Denise G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Paul D. Gragan
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04247

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last): Richard Glenn Haines
2. Date of Death: Month: January; Day: 26; Year: 2001
3. Time of Death: 7:15PM
4a. Facility Name (If not institution, give street and number): 12467 Clyde Young Rd.
4b. City, Town, or Location of Death: Keymar
4c. County of Death: Frederick
5. Social Security Number: 217-58-3092
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 46 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 4, 1954
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10e. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Keymar
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 12467 Clyde Young Rd.
10f. Zip Code: 21757
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): mechanic
16b. Kind of Business/Industry: auto garage
17. Father's Name (First, Middle, Last): Nathan L. Haines
18. Mother's Name (First, Middle, Maiden Surname): Gloria F. Mancha
19a. Informant's Name/Relationship (Type, Print): Patricia K. Haines/ wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12467 Clyde Young Rd. Keymar, MD 21757
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Tabor Union Cemetery
Date: 1/30/01
20c. Location - City or Town, State: Rocky Ridge, MD
21. Signature of Funeral Service Licensee: Catharine O. Hartzler
22. Name and Address of Facility: Hartzler Funeral Home, 404 S. Main St. Woodsboro, MD 21798

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Alcoholic Cirrhosis of Liver — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Asthma

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and Title of certifier: Casper E. Cline III MD
29c. License number: D 16428
29d. Date signed (Month, Day, Year): 1/29/01
30. Name and address of person who completed cause of death (Item 29a) (Type, Print): Casper E. Cline III 300 W 9th St. Frederick MD 21701

To Be Completed by State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

01-0538-029
DENISE L. HARRIS
ASP

AMENDED ITEMS# 23&27 per ME G792 022701 SS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04248

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Denise Lynette Henry Harris
2. Date of Death (Month, Day, Year): FEBRUARY 01 2001
3. Time of Death: 0033
4a. Facility Name (If not institution, give street and number): KENT QUEEN ANNE HOSPITAL
4b. City, Town, or Location of Death: CHESTERTOWN
4c. County of Death: KENT

Funeral Director

5. Social Security Number: 216-66-8616
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 44 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 12, 1956
9. Birthplace (State or Foreign Country): Chestertown, MD

Usual Residence of Decedent

10a. State: Maryland
10b. County: Kent
10c. City, Town or Location: Millington
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10250 Bigtone Road
10f. Zip Code: 21651
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager
16b. Kind of Business/Industry: Grocery
17. Father's Name (First, Middle, Last): Frank Henry
18. Mother's Name (First, Middle, Maiden Surname): Ella Yellowdy
19a. Informant's Name/Relationship (Type, Print): Donald F. Harris
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): PO Box 501, Millington, Maryland 21651
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Graves Chapel Cemetery
Date: 2/6/2001
20c. Location - City or Town, State: Millington, MD
21. Signature of Funeral Service Licensee: Kirk D. Fellows
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 370 W. Cypress Street, Millington, MD 21651

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. CARDIAC ARRHYTHMIA IN ASSOCIATION WITH CHRONIC BRONCHITIS AND PULMONARY EMPHYSEMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☑ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Pestaner, M.D.
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): FEBRUARY 02,2001

30. Name and address of person who completed cause of death (Item 28a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 07 2001
32. Registrar's Signature: Donna D. Frank

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04249

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Vaughn Frank Holmes

2. Date of Death: Month 1 Day 30 Year 01

3. Time of Death: 3:38

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 135-44-2263

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 47 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 31 1952

9. Birthplace (State or Foreign Country): New Jersey

Usual Residance of Decedent

10a. State: Delaware

10b. County: Sussex

10c. City, Town or Location: Georgetown

10d. Insida City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 6 East Adams Street

10f. Zip Coda: 19947

10g. Citizen of Whet Country?: U.S.A

11. Maritel Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Detas: 1973-74

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): | College (1-4or 5+): 5+

16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired): Forensic Elv.#

16b. Kind of Business/Industry: None

17. Father's Nema (First, Middla, Last): Frank Holmes

18. Mother's Name (First, Middla, Maidan Sumame): Maureen King

19a. Informent's Neme/Reletionship (Type, Print): Ingrid Holmes (Wife)

19b. Meiling Address (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda): 6 East Adams St.Georgetown,DE 19947

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Other (Specify)

20b. Placa of Disposition (Neme of cemetery, crematory or other piece): DE Veterans Cemetery

Date: 2/5/01

20c. Location - City or Town, State: Millsboro,DE

21. Signature of Funeral Service Licensee: Earl M. Wendy

22. Name and Address of Facility: Stewart Funeral Home 821 West Rd.Salisbury,Md.21801

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such es cardiac or respiratory errest, shock, or heart failura. List only one cause on eech line.

Approximete Interval Between Onsat and Death

Immediete Causa (Final disease or condition resulting in death)

a. G. I. Bleed — 30min

Due to (or as a consequence of):

b. Portal Hypertension — yrs

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disaase or injury thet initieted events resulting in death) Lest

Due to (or es e consequence of):

c. Esophageal Varices — yrs

Due to (or es e consequence of):

d. Cirrhosis — yrs

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Alcohol

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yas 2 [X] No

24b. Wera eutopsy findings aveilable prior to completion of cause of death? 1 [ ] Yas 2 [X] No

25. Wes case referred to medical examinar? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one): Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Data of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stata)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) and menner steted.

29b. Signeture end title of certifier: James Deane M.D.

29c. License number: D19822

29d. Date signed (Month, Dey, Year): 1/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J.O. Meadows 560 Riverside Dr. Salisbury MD 21801

State Registrar

31. Dete filed (Month, Day, Year): JAN 3 1 2001

32. Registrer's Signeture: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

VAUGHN HOLMES ss# 135-44-2263 4849 1/30/01 0392

16+1 VA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04250

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): OLDA ADELINE HUDSON

2. Dete of Deeth: Month JANUARY Dey 26 Yeer 2001

3. Time of Death: 5:22 PM

4e Facility Neme (If not institution, give street end number): ATLANTIC GENERAL HOSPITAL

4b. City, Town, or Location of Deeth: BERLIN

4c. County of Deeth: WORCESTER

Funeral Director

5. Social Security Number: 222-16-6002

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. lest birthdey): 76 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): OCT. 23, 1924

9. Birthplece (Stete or Foreign Country): MARYLAND

To Be Completed by Funeral Director

Usuel Residence of Decedent

10a. State: MARYLAND

10b. County: WORCESTER

10c. City, Town or Location: BISHOPVILLE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 12738 JARVIS ROAD

10f. Zip Code: 21813

10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐ Never Merried 2☒ Merried 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - Americen Indien, Bleck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): ACCOUNTANT

16b. Kind of Business/Industry: ACCOUNTING

17. Fether's Neme (First, Middle, Last): WALLACE CROPPER

18. Mother's Name (First, Middle, Meiden Sumeme): BLANCHE ESHAM

19a. Informent's Neme/Reletionship (Type, Print): FREDERICK E. HUDSON/HUSBAND

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 12738 JARVIS ROAD, BISHOPVILLE, MD 21813

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): ZION CEMETERY

Dete: 1/30/01

20c. Location - City or Town, Stete: BISHOPVILLE, MARYLAND

21. Signeture of Funerel Service Licensee: Charles W Hastings

22. Neme end Address of Fecility: HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975

Physician /Medical Examiner

23e. Pert I: Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth): a. ASCVD — FEW YEARS

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in deeth) Lest:

b.

Due to (or es e consequence of):

c.

Due to (or as e consequence of):

d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Deeth (Check only one): Hospitel: 1☐ Inpetient 2☒ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physicien**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☒ **Medical Examiner**: On the basis of exemineticn end/or investigetion, in my opinion, death occurred et the time, dete end piece, and due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier: Dorothy C. Holzworth, M.D.

29c. License number: D 06244

29d. Date signed (Month, Day, Year): 1-29-01

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): DOROTHY C. HOLZWORTH M.D. 203 SNOW ST. SNOW HILL, MD. 21863

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 3 1 2001

32. Registrer's Signeture: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Hudson, Adeline D. 10/23/24 - 1/26/01 1722 Hes

BDQ

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

ADMEND ITEM: 24A PER MD G793 3-6-01 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04251

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Leland Russell Holsinger Sr.

2. Data of Death Month Day Year: Jan. 31, 2001

3. Tima of Death: 1355

4a Facility Nama *(If not institution, give street and number)*: Memorial Hospital at Easton

4b. City, Town, or Location of Deeth: Easton

4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 726-05-0940

8. Sex: 1 [X] M 2 [ ] F

7. Aga *(In yrs. last birthday)*: 85 Yrs.

If Undar 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 21,1915

9. Birthplece *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. Stata: Maryland

10b. County: Caroline

10c. City, Town or Location: Ridgely

10d. Insida City Limits: 1 [ ] Yas 2 [X] No

10e. Street and Number: 24725 Holsinger Lane

10f. Zip Coda: 21660

10g. Citizen of Whet Country?: USA

11. Marital Status: 1 [ ] Nevar Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedant Evar in U.S. Armad Forces? 1 [X] Yas 2 [ ] No If Yes, Give Yeer or Detes: 1941 1962

13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxicen, Puarto Rican, etc.) 1 [ ] Yas 2 [X] No *Specify:*

14. Race - Americen Indian, Black, Whita, atc. *Specify:* white

15. Decedant's Education *(Specify only highest grade completed)*: Elamantary/Secondary (0-12): 11; Collaga (1-4or 5+): 4

16a. Decedant's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Senior Master Sergeant

16b. Kind of Businass/Industry: U.S.Air Force

17. Fethar's Nama *(First, Middle, Last)*: Adam Stayre Holsinger

18. Mothar's Nama *(First, Middle, Maiden Surname)*: Lydia Russell

19a. Informant's Name/Ralationship *(Type, Print)*: Leland Holsinger Jr son

19b. Mailing Addrass *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2302 W Labriego Dr. Tucson, Arizona 85741-3135

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Greensboro Cemetery

Data: Feb 5 2001

20c. Location - City or Town, Stata: Greensboro, Maryland

21. Signature of Funeral Service Licensee: Fleegle (Fleegle)

22. Nama and Addrass of Facility: Fleegle and Helfenbein Funeral Home PA PO Box 160 Greensboro, Maryland 21639

Physician /Medical Examiner

23a. Part1. Entar the disaasa, or complications that ceusad tha daath. Do not antar the mode of dying, such as cerdiac or raspiratory errest, shock, or haart failure. List only ona causa on aach lina.

Approximate Intervel Batween Onsat and Death

Immediata Causa (Final disaasa or condition rasulting in daath)

a. Internal exsanguination — minutes

Dua to (or as a consequance of):

b. Ruptured thoracic aorta aneurysm — hours

Dua to (or as a consequance of):

Sequantially list conditions, if eny, laading to immadiata ceusa. Entar Undarlying Cause (Diseese or injury that initieted events rasulting in daath) Last

c. Thoracic aorta atherosclerosis, severe — years

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the undarlying ceusa given in Part I.

Mild atherosclerosis of coronary arteries

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings aveilable prior to completion of ceusa of deeth? 1 [ ] Yas 2 [ ] No

25. Was cesa rafarred to medical examinar? 1 [ ] Yas 2 [X] No

26. Place of Death *(Check only one)*: Hospitel: 1 [ ] Inpatiant 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Rasidance 6 [ ] Othar *(Specify)*

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be datarmined

28a. Date of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, streat, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Cartifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, daath occurred at tha tima, data and place, end due to the cause(s) and manner es steted. 2 [ ] **Medical Examiner:** On the basis of axamination and/or invastigetion, in my opinion, deeth occurred at the tima, date and place, and due to tha causa(s) and manner stated.

29b. Signature and titla of certifier: Sahmel MD

29c. License number: D34633

29d. Data signed *(Month, Day, Year)*: 2-1-01

30. Name end eddrass of person who completed cause of daath (Item 23a) (Type, Print): Reinhardt O. Sahmel, M.D., Memorial Hospital, Easton, MD 21601

State Registrar

31. Data filed *(Month, Day, Year)*: FEB 05 2001

32. Registrar's Signetura: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Holsinger, Leland R.
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Caroline 2

24A

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Amend #5, 1/26/2001, BMW, Montg.Co.
Amend #12, 18, 1/22/2001, BMW, Montg.Co.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04252

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
RONALD HUBERT HARTMAN	JAN.	17,	2001	5:17 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
FAIRLAND NURSING HOME	SILVER SPRING	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
204-16-~~7968~~ 9768	1☒ M 2☐ F	75 Yrs.					MARCH 21, 1925	PA.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	MONTGOMERY	BETHESDA	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5909 SPRINGFIELD DR.	20816	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes ~~2☐ No~~ If Yes, Give Year or Dates: WWII	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondery (0-12)	College (1-4or 5+)		
	4	ENGINEER	PRIVATE

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
BLAIR MONROE HARTMAN	NANCY ELIZABETH Karlinsy ~~KARLINSKY~~

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
CONSTANCE JOYCE HARTMAN/WIFE	SAME AS ITEM #10

20a. Method of Disposition	20b. Piece of Disposition (Name of cemetery, crematory or other piece)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Ramoval from State 4☐ Donation 5☐ Other (Specify)	CHAMBERS CREMATORY	1/19/01	RIVERDALE, MD.

21. Signature of Funeral Sarvice Licensee	22. Nama and Addrass of Facility
▶ W. W. Chambers M00091	CHAMBERS FUNERAL HOMES, P.A., 5801 CLEVELAND AVE. RIVERDALE, MD. 20737

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart feilure. List *only one* ceuse on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disaase or condition resulting in death)	e. Cerebrovascular Accident	1d
	Due to (or es e consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Diabetes Mellitus
Hypercholesterolemia
Atrial Fibrillation

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of ceuse of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medicel examinar?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Locatlon (Straat and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or invastigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner steted.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Bennett Lo MD	D54488	1-18-2001

30. Nama and address of person who completed ceuse of death (Item 23a) (Type, Print)
Bennett So, MD, 8317 Cherry Lane, Laurel, MD 20707

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 22 2001	▶ B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

01-0482-013
mnmr
Henry Neal Ingle

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04253

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Henry Neal Ingle
2. Data of Death Month Day Year: January 29, 2001
3. Time of Death: 0950 am
4a. Facility Name (If not institution, give street and number): 85 Bond Street
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 220-42-9369
6. Sex: 1 M 2 F
7. Age (In yrs. last birthday): 53 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Sept 1 1947
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Carroll
10c. City, Town or Location: Westminster
10d. Inside City Limits: 1 Yes 2 No
10e. Street and Number: 85 Bond Street
10f. Zip Code: 21157
10g. Citizen of What Country? USA

11. Marital Status: 1 Never Married 2 Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No. If Yes, Give Year or Dates: 1966 1968
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Maintenance/Cook
16b. Kind of Business/Industry: American Legion Post 31

17. Father's Name (First, Middle, Last): Kies W. Ingle
18. Mother's Name (First, Middle, Maiden Surname): Eliza Osborne

19a. Informant's Name/Relationship (Type, Print): Glenda Ingle/wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 85 Bond Street Westminster, MD 21157

20a. Method of Disposition: 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Leisters Cemetery
Date: 2/2/2001
20c. Location - City or Town, State: Westminster, MD

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Pritts Funeral Home and Chapel 412 Washington Rd Westminster, MD21157

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Hypertensive and Atherosclerotic
Due to (or as a consequence of):
b. Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No
26. Place of Death (Check only one): Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 Residence 6 Other (Specify) at scene

27. Manner of Death: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: J Pestaner M.D
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): January 30, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001
32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04254

Kenney, Harmeline

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Physician /Medical Examiner — **To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): Lillian India Harmeline Kenney
2. Date of Death (Month, Day, Year): JANUARY 27 2001
3. Time of Death: 2:00AM
4a. Facility Name (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 217-09-6391
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 25, 1912
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 615 Chestnut Ave.
10f. Zip Code: 21204
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Blue Cross and Blue Sheild
16b. Kind of Business/Industry: Administrative Dept.

17. Father's Name (First, Middle, Last): George Plitt Von Eiff, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Fannie Moore

19a. Interment's Name/Relationship (Type, Print): June Von Eiff Shearer (niece)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8811 Clemsonville Rd. Unionville, MD 21204

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Linganore UMC Cemetery
Date: Jan. 30, 2001
20c. Location - City or Town, State: Unionville, MD

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Burrier-Queen Funeral Directors, P.A. 1212 West Old Liberty Rd. Winfield, MD 21784

Physician /Medical Examiner — **Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Aspiration pneumonia	1 day
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypercalcemia - uncertain etiology

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: W. Anthony Riley, MD
29c. License number: D25205
29d. Date signed (Month, Day, Year): January 27, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W.A. Riley GBMC 6701 N. Charles St. Balto. Md 21204

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001
32. Registrar's Signature: Jennie G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04255

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DOROTHY MAE KRUSE

2. Data of Death — Month: FEB; Day: 2; Year: 2001

3. Time of Death: 2:55 A.M

4a. Facility Name *(If not institution, give street and number)*: CIVISTA MEDICAL CENTER

4b. City, Town, or Location of Death: LAPLATA

4c. County of Death: CHARLES

Funeral Director

5. Social Security Number: 578 38 2283

6. Sex: 1 ☐ M 2 ☒ F

7. Age *(In yrs. last birthday)*: 84 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: SEPT 6 1916

9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedant

10a. State: Maryland

10b. County: Charles

10c. City, Town or Location: La Plata

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: One Magnolia Drive

10f. Zip Code: 20646

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): Unknown; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Clerk

16b. Kind of Business/Industry: Sales

17. Father's Name *(First, Middle, Last)*: Charles M. Alexander

18. Mother's Name *(First, Middle, Maiden Surname)*: Daisy I. McElroy Alexander

19a. Informant's Name/Relationship *(Type, Print)*: Ruth A. Coombs (Niece)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8410 Billingsley Rd White Plains, MD 20695

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Trinity Memorial Gardens

Date: 2-6-01

20c. Location - City or Town, State: Waldorf, MD

21. Signature of Funeral Service Licensee: John H. Eberwein M00173

22. Name and Address of Facility: Eberwein Funeral Services 4433 White Plains La White Pls., M D 20695

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARRYTHMIA — Minutes

Due to (or as a consequence of):

b. CARDIOVASCULAR DISEASE — YRS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

CEREBROVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ATTENDING

29c. License number: D-44436

29d. Date signed *(Month, Day, Year)*: Feb 02 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ASHVINKUMAR J. PATEL MD 102 PAUL MELLON DR. STE. 102 WALDORF, MD. 20602

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 05 2001

32. Registrar's Signature: Jessica G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Dorothy M. Kruse
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04256

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Stanley Mitchell Keen
2. Dete of Deeth — Month: Jan. Dey: 30 Yeer: 2001
3. Time of Death: 11:00am
4e Facility Name *(If not institution, give street end number)*: 627 Chapel Terrace
4b. City, Town, or Location of Deeth: Havre de Grace
4c. County of Deeth: Harford

Funeral Director

5. Social Security Number: 220-05-7100
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. lest birthday)*: 87 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Yeer)*: 03/27/1913
9. Birthplece *(Stete or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. Stete: MD
10b. County: Harford
10c. City, Town or Location: Havre de Grace
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street end Number: 627 Chapel Terrace
10f. Zip Code: 21078
10g. Citizen of Whet Country?: USA

11. Meritel Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11th; College (1-4or 5+):
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Photographer
16b. Kind of Business/Industry: Government

17. Father's Name *(First, Middle, Last)*: Carl Keen
18. Mother's Name *(First, Middle, Maiden Surname)*: Ida Cain

19a. Informant's Name/Relationship *(Type, Print)*: Thelma Keen- Wife
19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, State, Zip Code)*: 627 Chapel Terrace, Havre de Grace, MD 21078

20e. Method of Disposition: 1 [ ] Burial 2 [X] Cremetion 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: R.A. Ferris & Co. Inc.
Dete: 2/2/01
20c. Location - City or Town, State: West Chester, PA

21. Signature of Funeral Service Licensee: Dulaine M. Smith
22. Neme end Address of Feclity: Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. — Approximate Interval Between Onset end Deeth

Immediate Ceuse (Final disease or condition resulting in death)
a. COPD
Due to (or es e consequence of):
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in deeth) Lest
b. Chronic Atrialfibrillation
Due to (or es e consequenca of):
c. Parkinson's Disease
Due to (or es e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of deeth? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was en eutopsy performed? 1 [ ] Yes 2 [ ] No
24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No
28. Place of Death *(Check only one)*: Hospitel: 1 [ ] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) and manner es stated. 2 [ ] **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ Mi Sup Sim MH
29c. License number: D 46412
29d. Date signed *(Month, Dey, Yeer)*: 1/31/2001

30. Neme and address of person who completed ceuse of deeth (Item 23a) (Type, Print): Mi Sup Sim 319 S. Union Ave Hdg MD 21078

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: FEB 1 2001
32. Registrar's Signature: ▶ Geneva B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Maryland Department of Health and Mentel Hygiene. **Important: If item 27 is merkedc other than "netural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the deeth certificele be executed within 24 hours efter deeth.
To the Funeral Director: After this certificate hes been signed by the ettending physician end completely filled in by the funerel director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04257

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John David Samuel Lambert
2. Date of Death (Month, Day, Year): January 31 2001
3. Time of Death: 2040
4a. Facility Name (If not institution, give street and number): Northhampton Manor Health Care Center
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick County

Funeral Director

5. Social Security Number: 214-28-5620
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 73 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 16, 1927
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick County
10c. City, Town or Location: Keymar
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 12431 Detour Road
10f. Zip Code: 21757
10g. Citizen of Whet Country?: United States

11. Maritel Status: 1 [ ] Never Married 2 [X] Merried 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Detes: 1946–1947
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - Americen Indien, Bleck, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 7 College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): plate maker
16b. Kind of Business/Industry: business forms printer

17. Fether's Neme (First, Middle, Last): Raymond Lambert
18. Mother's Name (First, Middle, Maiden Surneme): Mary Catherine Sigler

19a. Informent's Neme/Reletionship (Type, Print): Jonathan D. Lambert / son
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 12431 Detour Road Keymar, Maryland 21757

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Keysville Union Cemetery
Dete: Feb 3 2001
20c. Location - City or Town, Stete: Keymar, Maryland

21. Signature of Funerel Service Licensee: Alan C. Purvis MO1072
22. Name and Address of Fecility: Skiles Funeral Home 136 East Baltimore Street Taneytown, MD 21787

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on eech line. — Approximete Interval Between Onset end Death

Immediete Cause (Finel diseese or condition resulting in deeth)
a. MOLASTATIC BLADDER CANCER — ~ 1/2 year
Due to (or es e consequence of):
Sequentially list conditions, if eny, leading to immediete ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: CHRONIC OBSTRUCTIVE PULMONARY DISEASE; HYPERTENSION; CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1 [ ] Yes 2 [ ] No

25. Was cese referred to medicel examiner? 1 [ ] Yes 2 [X] No
26. Piece of Deeth (Check only one): Hospitel: 1 [ ] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Menner of Death: 1 [X] Nelurel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined
28a. Date of Injury (Month, Dey Yeer)
28b. Time of Injury
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Ptece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end ptece, end due to the ceuse(s) end menner steted.
29b. Signature end title of certifier: MD
29c. License number: D32171
29d. Date signed (Month, Dey, Yeer): 2/1/01
30. Neme and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): Richard L. Gough, M.D. 19 Frederick Street Walkersville, MD 21793

State Registrar

31. Dete filed (Month, Dey, Yeer): FEB 01 2001
32. Registrer's Signeture: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be contacted at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

RKD

01-0478-017

GILBERT

LOW AMENDED ITEMS# 23,ptII,& 27 per ME G792 030101 SS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04258

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gilbert Low

2. Date of Death: Month JANUARY Day 28, Year 2001

3. Time of Death: 6:05P.M.

4a. Facility Name (If not institution, give street and number): CIVISTA MEDICAL CENTER

4b. City, Town, or Location of Death: LA PLATA

4c. County of Death: CHARLES

Funeral Director

5. Social Security Number: 219-58-9365

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 49 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 26, 1951

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Fort Washington

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 410 Potomac Valley Dr.

10f. Zip Code: 20744

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanic

16b. Kind of Business/Industry: Aggregate Industries

17. Father's Name (First, Middle, Last): Bossie Low

18. Mother's Name (First, Middle, Maiden Surname): Juanita Brown

19a. Informent's Name/Relationship (Type, Print): Doris Lee/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 202 Staton Dr. Upper Marlboro, Maryland 20774

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Resurrection Cem.

Date: 2/03/01

20c. Location - City or Town, State: Clinton, Maryland

21. Signature of Funeral Service Licensee: Lloyd E. [illegible] m0191

22. Name and Address of Facility: Adams Funeral Home P.A..Aquasco MD 20608

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: BACTEREMIA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stephen S. Radentz, M.D.

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): JANUARY 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04259

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Melvin B. Mays
2. Date of Death (Month, Day, Year): Jan 31, 2001
3. Time of Death: 12:32 pm
4a. Facility Name *(If not institution, give street and number)*: Long View Nursing Home
4b. City, Town, or Location of Death: Manchester
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 185-01-4092
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 89 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sep 25, 1911
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residance of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Hampstead
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 1200 North Carroll Street
10f. Zip Code: 21074
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Navar Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1 ☐ Yes 2 ☒ No — If Yas, Giva Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedant's Education *(Specify only highast grada complatad)*: Elamantary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Maintenance Worker
16b. Kind of Business/Industry: City of Baltimore

17. Fathar's Nama *(First, Middla, Last)*: Thomas Mays
18. Mother's Name *(First, Middle, Maiden Surname)*: Carrie Baublitz

19a. Informant's Name/Relationship *(Type, Print)*: Carol L. Siegman, daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1616 Manchester Rd, Westminster, MD 21157

20a. Mathod of Disposition: 1 ☒ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Wesley Cemetery
Date: 2/02/2001
20c. Location - City or Town, State: Hampstead, MD

21. Signature of Funeral Service Licensee: Steven Weldon M00723
22. Nama and Address of Facility: Eline Funeral Home, 934 South Main St, Hampstead, MD 21074

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona causa on aach lina. — Approximata Interval Between Onset and Death

Immediata Causa (Final disaasa or condition rasulting in death): a. Richardson's Disease — Due to (or as a consequence of):

Sequentially list conditions, if any, laading to immediata causa. Entar Underlying Cause (Diseasa or Injury that initiated avants rasulting in daath) Last:
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was casa rafarrad to medical examinar? 1 ☐ Yas 2 ☒ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Mannar of Death: 1 ☒ Natural 2 ☐ Accidant 3 ☐ Suicida 4 ☐ Homicida 5 ☐ Panding invastigation 6 ☐ Could not be determined
28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28a. Place of Injury - At homa, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Cartifier *(Check only one)*: 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signatura and title of cartifiar
29c. License number: 33165
29d. Date signed *(Month, Day, Year)*: 2/1/01
30. Nama and addrass of parson who complatad causa of death (Item 23a) (Type, Print): Steven Sachs 1111 Hanover Pike Manchester MD 21157

State Registrar

31. Data filed *(Month, Day, Year)*: FEB 01 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04260

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOSEPH JAMES MURPHY
2. Date of Death Month Day Year: JANUARY 31, 2001
3. Time of Death: 5:44PM
4a. Facility Neme *(If not institution, give street and number)*: ST MARY' S HOSPITAL
4b. City, Town, or Location of Death: LEONARDTOWN
4c. County of Deeth: ST MARY'S

Funeral Director

5. Social Security Number: 035 16 5022
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 76 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 29 1924
9. Birthplace *(State or Foreign Country)*: Rhode Island

Usual Residence of Decedent

10a. Steta: Maryland
10b. County: St Mary's
10c. City, Town or Location: Leonardtown
10d. Insida City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 21585 Peabody St
10f. Zip Coda: 20650
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yas 2 [X] No *Specify:*
14. Raca - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elemantary/Secondary (0-12): 10; Collage (1-4or 5+):
16a. Decedent's Usual Occupetion *(Give kind of work done during most of working lifa. DO NOT use ratired)*: Installer
16b. Kind of Business/Industry: Construction

17. Fathar's Nama *(First, Middle, Last)*: John J. Murphy
18. Mother's Name *(First, Middle, Maidan Surname)*: Johanna Shea Murphy

19a. Informant's Name/Relationship *(Type, Print)*: Wayne Garofolo (Step-son)
19b. Maiting Addrass *(Street and Number or Rural Route Numbar, City or Town, State, Zip Code)*: 12616 Kern Wood La. Bowie, Maryland 20715

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from Stata 4 [ ] Donetion 5 [ ] Other *(Specify)*
20b. Pteca of Disposition *(Name of cemetery, crematory or other place)*: Maryland Veterans Cem
Data: 2-7-01
20c. Location - City or Town, Stata: Cheltenham, MD

21. Signature of Funeral Service Licansee: John H. Eberwein M00173
22. Name and Address of Facility: Eberwein Funeral Services 4433 White Pls. La. White Pls., MD 20695

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused tha deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one causa on eech line.

Approximate Intervel Between Onset end Death

Immediate Causa (Final disease or condition resulting in daath)
a. Respiratory failure — few hours

Due to (or as a consaquence of):
b. COPD exacerbation — few hours

Sequantially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last
Due to (or es a consequenca of):
c. Possible Sepsis — 1 day.

Due to (or es e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings available prior to compteion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case raferred to medical examiner? 1 [ ] Yes 2 [X] No
26. Placa of Daath *(Check only ona)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Rasidenca 6 [ ] Other *(Specify)*

27. Mannar of Deeth: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Data of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Dascribe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the tima, data and plece, and dua to tha causa(s) and mannar as stated. 2 [ ] **Medical Examiner:** On the besis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and ptace, and dua to tha causa(s) and manner stated.

29b. Signatura and titla of certifier: A Shah
29c. License number: D 47066
29d. Date signed *(Month, Day, Year)*: 2-1-01

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print): DR. AVANI D. SHAH HOLLYWOOD, MD. 20636

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 05 2001
32. Registrar's Signature: Donna B. Sparks

Baltimore, Maryland 21215-0036

permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

NAME: JOSEPH J MURPHY

DHMH 16 Rev 6/95

ORIGINAL

5+1VA

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04261

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Gaede Mowbray
2. Date of Death Month / Day / Year: January 26, 2001
3. Time of Death: 4:20PM
4a. Facility Name *(If not institution, give street and number)*: Magnolia Hall Nursing Home
4b. City, Town, or Location of Death: Chestertown
4c. County of Death: Kent

Funeral Director

5. Social Security Number: 161-10-1801
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 94 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 17, 1906
9. Birthplace *(State or Foreign Country)*: NewYork

Usual Residence of Decedent

10a. State: Maryland
10b. County: Kent
10c. City, Town or Location: Chestertown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 111 Birch Run Road
10f. Zip Code: 21620
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Domestic

17. Father's Name *(First, Middle, Last)*: Anton Henry Gaede
18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret MacNeil

19a. Informant's Name/Relationship *(Type, Print)*: Elaine Knight Naper
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 111 Birch Run Road Chestertown, Maryland 21620

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Cremation Cntr — Date: 1/27/01
20c. Location - City or Town, State: Stevensville, MD

21. Signature of Funeral Service Licensee: Fellows, Helfenbein, and Newnam Funeral Home
22. Name and Address of Facility: Fellows, Helfenbein, and Newnam Funeral Home 130 Speer rd. Chestertown, Md. 21620

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. END STAGE ALZHEIMERS DISEASE — 75yrs.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: OSTEOPOROSIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John A. Noble MD
29c. License number: D0041587
29d. Date signed *(Month, Day, Year)*: 1/28/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Helen A. Noble, 122 Speer Road, Chestertown, Maryland 21620

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 30 2001
32. Registrar's Signature: D. Spath

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04262

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Julia Misurowski
2. Date of Death (Month, Day, Year): Jan. 24, 2001
3. Time of Death: 12:30 pm
4a. Facility Name (If not institution, give street and number): 3126 Millington Road
4b. City, Town, or Location of Death: Millington
4c. County of Death: Queen Anne's

Funeral Director

5. Social Security Number: 164-36-2240-A
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 100 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 9, 1900
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Queen Anne's
10c. City, Town or Location: Millington
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3126 Millington Road
10f. Zip Code: 21651
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 3yrs; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Landlord
16b. Kind of Business/Industry: Housing

17. Father's Name (First, Middle, Last): Andrew Harchar
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Misko

19a. Informant's Name/Relationship (Type, Print): Marie Kalesnik Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3126 Millington Road Millington, Md. 21651

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chester Rural Cemetery
Date: 1/29/01
20c. Location - City or Town, State: Pennsylvania

21. Signature of Funeral Servica Licansee: Joan Fellows
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home 370 W. Cypress St. Millington, Md. 21651

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardio Respiratory Arrest	1 hour
Due to (or as a consequenca of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Arteriosclerotic Cardio Vascular Disease	
Due to (or as a consequenca of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part i.

Hypothyroid/HTN/Gout/Arthritis/HxCHF
Hx Dysrhythmia.

23b. Did tobacco use contribute to the cauae of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Neil Stoddard
29c. License number: D50996
29d. Date signed (Month, Day, Year): 1/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Neil Stoddard MD. 100 Brecon St. Chestertown MD 21620

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

JAN 2 8 2003

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04263

AMEND ITEM 7 per fh G796 061501 SS

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELSA ELIZABETH MONTOURI

2. Date of Death: Month 01 Day 12 Year 2001

3. Time of Death: 11:30 PM

4a. Facility Name (If not institution, give street end number): CORSICA HILLS NURSING HOME

4b. City, Town, or Location of Death: CENTREVILLE

4c. County of Death: QUEEN ANNE'S

Funeral Director

5. Social Security Number: 116-10-5576

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 94 ~~95~~ Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): 07/13/1906

9. Birthplece (State or Foreign Country): NORWAY

Usual Residence of Decedent

10a. State: MD

10b. County: QUEEN ANNE'S

10c. City, Town or Location: CENTREVILLE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 205 ARMSTRONG STREET

10f. Zip Code: 21617

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Americen Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): OWNER/OPERATOR

16b. Kind of Business/Industry: RESTAURANT

17. Father's Name (First, Middle, Last): FRIDTJOV ROSENLIND

18. Mother's Name (First, Middle, Maiden Surname): ANNA OLSON

19a. Informent's Name/Relationship (Type, Print): FRANK SJOLIE / NEPHEW

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 7 COLBY COURT UNIT 4-296 BEDFORD, NH 03110

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): CHESAPEAKE CREMATION CTR.

Date: 1/15/01

20c. Location - City or Town, Stete: STEVENSVILLE, MD

21. Signature of Funeral Service Licensee: Thomas K. Helfenbein

22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 408 S. LIBERTY STREET CENTREVILLE, MD 21617

Physician /Medical Examiner

23a. Part1. Enter the disease, or comnlications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Intervel Between Onset end Death

Immediate Cause (Final disease or condition resulting in deeth): e. Urinary tract infection — 2wk

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last:

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HTN

Coronary Heart Disease

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: ~~4☐~~ 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: ~~1☐~~ 1☐ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred et the time, date and place, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of exemination end/or investigetion, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) end manner steted.

29b. Signature and title of certifier: [signature]

29c. License number: D32036

29d. Date signed (Month, Dey, Yeer): 1/14/2001

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Gary T Sprouse 21kp D. Drake Drive Chester, MD 21619

State Registrar

31. Date filed (Month, Day, Year): JAN 18 2001

32. Registrar's Signature: G. Sparks

To be Completed by Funeral Director

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

BD 7/13/06

RC 1/12/01 11:30p

Elsa Montouri D.A. 7/13

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04264

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GLADYS MARIE NELSON
2. Date of Death Month Day Year: JAN. 29, 2001
3. Time of Death: 2:00 PM
4a. Facility Name (If not institution, give street and number): CARROLL COUNTY GENERAL HOSPITAL
4b. City, Town, or Location of Death: WESTMINSTER
4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: 212-07-0217
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2/4/1918
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD.
10b. County: CARROLL
10c. City, Town or Location: MANCHESTER
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3303 KENSINGTON SQUARE
10f. Zip Code: 21102
10g. Citizen of What Country?: USA.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elamentary/Secondery (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): KEY PUNCH OPERATOR
16b. Kind of Business/Industry: STATE GOVERNMENT

17. Father's Name (First, Middle, Last): NORWOOD MANGER
18. Mother's Name (First, Middle, Maiden Surname): BESSIE FENWICK

19a. Informant's Name/Relationship (Type, Print): KEENER E. NELSON -HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3303 KENSINGTON SQUARE, MANCHESTER, MD. 21102

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): DRUID RIDGE CEMETERY | Date: 2/1/01
20c. Location - City or Town, State: PIKESVILLE, MD.

21. Signature of Funeral Service Licensee: Thos Fletcher
22. Name and Address of Facility: FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
e. Colon cancer c mets

Due to (or as a consequence of):
b. hypoxemia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of):
c. CHF

Due to (or as a consequence of):
d. hypothyroidism

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Atrial fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D51072
29d. Date signed (Month, Day, Year): 1/29/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHAWN Taylor-Hollins Carroll County General Hospital 200 Memorial Dr. Westminster MD 21157

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04265

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Dorothy B. Nagle	January 30, 2001	6:45 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Stella Maris Hospice	Timonium	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-26-1196	1☐ M 2☒ F	92 Yrs.			Jan. 26, 1909	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	N/A	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3333 Cliftmont Avenue	21213	U.S.A.

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yaar or Datas:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired)	16b. Kind of Businass/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8th Grade		Homemaker	Own Home

17. Fathar's Name (First, Middle, Last)	18. Mother's Nama (First, Middle, Maiden Surname)
Robert M. Eierhart	Betty Collins

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code)
Mrs. Doris J. Haag (daughter)	204 Kimary Ct., # 2A, Forest Hill, MD 21050

20a. Method of Disposition	20b. Place of Disposition (Name of cematery, cramatory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Othar (Specify) Entombment	Moreland Mem'l Park Maus.	2/2/01	Baltimore, Maryland

21. Signature of Funeral Service Licensaa	22. Name and Address of Facility
▶ Brian A. Millan	Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

Physician /Medical Examiner

23a. Part1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ona causa on each line.

Approximata Intarval Batween Onset and Death

Immediata Causa (Final disaase or condition resulting in death)

a. **Colon Cancer**

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Dua to (or as e consequenca of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yas 2☐ No

25. Was casa rafarred to medical axaminar?	26. Placa of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be detarmined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at tha tima, date and place, and dua to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at tha tima, data and place, and dua to tha cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Data signed (Month, Day, Year)
▶	D43725	1/30/01

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

Dr. Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 21093

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signatura
FEB 1 2001	▶ Karen P. Yeats

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

January 30, 2001 6:45 a.m.

Dorothy Nagle

Division of Vital Records, P.O. Box 68760,

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 01266

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DORA PICCOLA BARKLEY NICHOLS

2. Date of Death: Month JANUARY Day 27 Year 2001

3. Time of Death: 1135

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 218-24-5444-A

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12-25-23

9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD. | 10b. County: WICOMICO | 10c. City, Town or Location: MARDELA SPRINGS | 10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: RT. 2 - BOX 655 | 10f. Zip Code: 21837 | 10g. Citizen of What Country?: USA

11. Maritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+): 3

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DOMESTIC

16b. Kind of Business/Industry: WOLF FAMILY

17. Father's Name (First, Middle, Last): BENJAMIN BARKLEY

18. Mother's Neme (First, Middle, Maiden Sumeme): GERTAUDE WATERS BARKLEY

19a. Informent's Neme/Reletionship (Type, Print): EUGENE NICHOLS - SON

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 10218-OLD OCEAN CITY BLVD. BERLIN, MD. 21811

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): ZION CHURCH CEMETARY | Date: 2/3/01

20c. Location - City or Town, Stete: SHARPTOWN, MD.

21. Signature of Feneral Service Licensee: [signature]

22. Neme end Address of Feciility: BENNIE SMITH F/H 917-W. ISABELLA ST. SALISBURY, MD. 21801

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

		Approximete Intervel Between Onset and Death
Immediate Ceuse (Final disease or condition resulting in death) a.	BRAIN STEM FAILURE	18 DAYS
Due to (or as e consequence of): b.	MASSIVE CEREBELLAR HEMORRHAGE	18 DAYS
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest — Due to (or es e consequence of): c.	ARTERIAL HYPERTENSION	YEARS
Due to (or es e consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: SEVERE MITRAL REGURGITATION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Deeth (Check only one): Hospitel: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer): N/A

28b. Time of Injury: M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and piece, end due to the cause(s) and menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: [signature] MD, PhD.

29c. License number: D0054OR48

29d. Dete signed (Month, Dey, Yeer): 1-27-01

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print): JACEK M. MALIK MD PhD, PENINSULA NEUROSURGICAL ASSOCIATES, PA SALISBURY MD

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 31 2001

32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DORA NICHOLS

3 DQ

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04267

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLOTTE H. O'BRIEN
2. Date of Death Month Day Year: JAN 28, 2001
3. Time of Death: 6:45 PM
4a. Facility Name (If not institution, give street and number): WESTMINSTER NURSING HOME
4b. City, Town, or Location of Death: WESTMINSTER
4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: 578-26-2258
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 98 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11/9/1902
9. Birthplace (State or Foreign Country): GERMANY

Usual Residence of Decedent

10a. State: MD.
10b. County: CARROLL
10c. City, Town or Location: WESTMINSTER
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1606 VALLEY DR.
10f. Zip Code: 21157
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SECRETARY
16b. Kind of Business/Industry: WHOLESALERS

17. Father's Name (First, Middle, Last): HEINRICH KESEMEYER
18. Mother's Name (First, Middle, Maiden Surname): LOUISE MEYER

19a. Informant's Name/Relationship (Type, Print): JULIA FORD -STEP-DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1606 VALLEY DR., WESTMINSTER, MD. 21157

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): LAKE VIEW MEM. PARK | Date: 1/31/01
20c. Location - City or Town, State: ELDERSBURG, MD.

21. Signature of Funeral Service Licensee: ▶ R Lee Fletcher
22. Name and Address of Facility: FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): e. Carcinoma of the Colon — 6 mo

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Robt J. Mann MD
29c. License number: 032882
29d. Date signed (Month, Day, Year): 1/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert L. Mann 114 Business Center Dr. Reisterstown, MD

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: ▶ Bonnie G Sparks

2136

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

01-0412-015
crn
William H. Oathout
Amend Item#7 perFHG796 6/14/01 EW

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04268

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
William H. Oathout	January 25, 2001	4:51 A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Route 272 and Lums Road	North East	Cecil

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
130-44-1962	1☒ M 2☐ F	~~47~~ 46 Yrs.			November 6, 1954	New York

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
New York	Greene	Cairo	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4557 Route 23 Apartment 7	12413	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No *Specify:*	*Specify:* White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Truck Driver	Transport

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Oathout	Shirley Dwyer

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Lori A. Oathout / Spouse	P.O. Box 507 Leeds, New York 12451

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Wiltwyck Crematory	January 30, 2001	Kingston, New York

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	McDonald Funeral Home, 886 Columbia Street, Hudson, New York 12534

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) at scene

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	O.C.M.E.	January 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Aaron Locke, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 26 2001	▶ [signature] D. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04269

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Allan Washington Price

2. Dete of Deeth — Month: January, Dey: 24, Yeer: 2001

3. Time of Deeth: 6:00 p.m.

4a. Fecility Name *(If not institution, give street end number)*: Chestertown Nursing & Rehab Center

4b. City, Town, or Location of Death: Chestertown

4c. County of Deeth: Kent

Funeral Director

5. Sociel Security Number: 578-10-6576

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 92 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Yeer)*: September 11, 1908

9. Birthplece *(State or Foreign Country)*: Rock Hall, MD

Usual Residence of Decedent

10e. Stete: Maryland

10b. County: Kent

10c. City, Town or Location: Rock Hall

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street end Number: 5535 Boundary Avenue

10f. Zip Code: 21661

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - Americen Indian, Bleck, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 8; College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Electrician

16b. Kind of Business/Industry: Electrical

17. Father's Name *(First, Middle, Last)*: Frank C. Price

18. Mother's Name *(First, Middle, Maiden Surname)*: Nora Crouch

19a. Informent's Name/Relationship *(Type, Print)*: Allan Frank Price

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 9505 Evergreen Street, Silver Spring, MD 20901

20a. Method of Disposition: 1☒Buriel 2☐Cremetion 3☐Removel from Stete 4☐Donetion 5☐Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, crematory or other piece)*: Wesley Chapel Cemetery

Date: 1/27/2001

20c. Location - City or Town, State: Rock Hall, MD

21. Signature of Funeral Service Licensee: Fellows, Helfenbein & Newnam Funeral Home, P.A.

22. Name end Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Interval Between Onset end Death

Immediete Ceuse (Finel disease or condition resulting in death)

a. Esophageal dysmitility — 10 yr

Due to (or es a consequence of):

b. Esophageal stricture

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ASCVD

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☑No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☑Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Yeer)*

28b. Time of Injury

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of Certifier:

29c. License number: D36054

29d. Date signed *(Month, Day, Yeer)*: 1/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Patrick J. Shanahan 120 Speer Rd. Chestertown, MD 21620

State Registrar

31. Date filed *(Month, Day, Yeer)*: JAN 26 2001

32. Registrar's Signature: P. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

8

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04270

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Virginia Lee Pylant

2. Date of Death Month Dey Year: Jan 26, 2001

3. Time of Death: 10:25 pm

4a Facility Neme (If not institution, give street and number): Carroll Lutheran Village Health Care Center

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 219-12-5414

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr 1, 1922

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. Stete: MD

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 205 St. Mark Way

10f. Zip Code: 21158

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12; College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Office Clerk

16b. Kind of Business/Industry: Mass Transit Administration

17. Fether's Neme (First, Middle, Last): Walter Maxie Pylant

18. Mother's Name (First, Middle, Maiden Sumame): Lyda Oral Boone

19a. Informant's Neme/Reletionship (Type, Print): Kenneth Hoefer-Trust Officer

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11817 Reisterstown Rd. Reisterstown, MD 21136

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Lake View Memorial

Dete: 1 31 2001

20c. Location - City or Town, Stete: Eldersburg, Maryland

21. Signeture of Funerel Service Licensee: John K. Agle

22. Name and Address of Facility: Pritts Funeral Home and Chapel, P.A. 412 Washington Rd. Westminster, MD 21157

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Finel disease or condition resulting in death)

e. Acute Myocardial Infarction — 2dys

Due to (or as a consequence of):

Sequentielly list conditions, if any, leading to immediele cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last

b. End Stage Coronary Artery Dz — 4mos

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

Recent ® CVA c ⓛ Hemiparesis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deth (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ Certifying Physician- To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner es stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) and manner stated.

29b. Signeture end title of certifier

29c. License number: D37949

29d. Date signed (Month, Day, Year): Jan 29th 2001

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): Alexander Brodzinski, PA-C 295 Sener Ave, Westminster, MD 21157

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signature: G Sparks

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ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet tha death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by tha funeral director, pega 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04271

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Bridget E. Rose
2. Date of Death — Month: January Day: 28 Year: 2001
3. Time of Death: 4:20am
4a. Facility Name *(If not institution, give street and number)*: 5701 White Rock Road
4b. City, Town, or Location of Death: Sykesville
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 213-03-1670
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Apr 10 1916
9. Birthplace *(State or Foreign Country)*: Md

Usual Residence of Decedent

10a. State: Md
10b. County: Carroll
10c. City, Town or Location: Sykesville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5701 White Rock Road
10f. Zip Code: 21784
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* white

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 — College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: clerk
16b. Kind of Business/Industry: SSA

17. Father's Neme *(First, Middle, Last)*: Frank Welsch
18. Mother's Name *(First, Middle, Maiden Sumeme)*: Anna Marek

19a. Informent's Neme/Relationship *(Type, Print)*: Henry S. Rose (spouse)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 5701 White Rock Rd., Sykesville, Md 21784

20e. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donetion 5☒ Other *(Specify)* entombment
20b. Placa of Disposition *(Name of cemetery, cremetory or other piece)*: Crest Lawn Mausoleum — Dete: 1-31-2001
20c. Location - City or Town, State: Marriottsville, Md

21. Signature of Funerel Service Licensee: ▶ Paige Haight Herbert
22. Name and Address of Facility: Haight Funeral Home & Chapel, P.O. Box 195 Sykesville, Md. 21784

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediete Cause (Final diseese or condition resulting in death): a. Lymphoma — 14 months

Due to (or as e consequence of):

Sequentielly tist conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or es a consequence of):
c. Due to (or as e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco uae contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings aveilable prior to completion of ceuse ot death? 1☐ Yes 2☐ No

25. Was case referred to medicel examiner? 1☐ Yes 2☒ No

26. Piece of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted.

29b. Signature end title of certifier: ▶ Steven Billet, MD
29c. License number: D27211
29d. Date signed *(Month, Dey, Year)*: 1/29/2001

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print): Steven Billet, MD 6190 Georgetown Blvd, Eldersburg MD 21784

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 3 0 2001
32. Registrar's Signature: ▶ Denise G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04272

Patient known as Margaret Rickards

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret Ruth Rickards

2. Date of Death — Month: January Day: 30 Year: 2001

3. Time of Death: 6:31am

4e. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death:

Funeral Director

5. Social Security Number: 247-44-0388

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sep 21,1914

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Hampstead

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4426 Black Rock Rd #4

10f. Zip Code: 21074

10g. Citizan of What Country?: USA

11. Meritel Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Americen Indian, Bleck, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed) — Elementery/Secondary (0-12): — College (1-4or 5+): 2

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Housekeeper

16b. Kind of Business/Industry: Home Care

17. Fether's Neme (First, Middle, Last): William Stauffer

18. Mother's Name (First, Middle, Maidan Surname): Sara Bowen

19e. Informent's Name/Reletionship (Type, Print): William Cooley, son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 2020 Channel Rd, Pylesville, MD 21132

20e. Method of Disposition: 1☒ Burlel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Othar (Specify)

20b. Place of Disposition (Nema of cemetery, crematory or other place): Lake View Memorial Park

Date: 2/01 2001

20c. Location - City or Town, Steta: Sykesville, MD

21. Signeture of Funeral Service Licensee: Steven W Eline M00723

22. Name end Address of Feclity: Eline Funeral Home 934 South Main St, Hampstead, MD 21074

To Be Completed by Funeral Director

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mentel Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23a. Part1. Enter the diseesa, or complicetions that causad tha daeth. Do not antar tha moda of dying, such es cerdiec or respiretory errest, shock, or haart failura. List only ona causa on aech lina.

Approximete Interval Batween Onset end Deeth

Immediate Ceusa (Finel diseese or condition resulting in deeth)

a. Cardiogenic Shock — 3 days

Due to (or es e consequence ol):

b. Acute Myocardial Infarction — 3 days

Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Cause (Disaase or Injury thet initieted events resulting in death) Last

Due to (or es e consaquence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Tension Pneumothorax

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveilable prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Daeth (Check only one) — Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA — Othar: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29e. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, daath occurred et tha tima, data and place, end dua to the ceuse(s) end menner as steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, daath occurrad et the time, dete end piece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: Karen Babitt MD

29c. License number: RES 000

29d. Data signed (Month, Day, Year): January 30, 2001

30. Name and eddress of person who completed ceuse of deeth (Item 23a) (Type, Print): Karen Babitt, 2401 West Belvedere Avenue, Baltimore, MD 21215

State Registrar

31. Dete filed (Month, Day, Year): JAN 30 2001

32. Registrer's Signeture: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Amended Item 23a, Part I per Physician, Carroll County, 01/31/01 wjl

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No 2001 04273

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ROBERT CLINTON RILL, SR
2. Date of Death Month Day Year: JAN 27, 2001
3. Time of Death: 8:00 pm

4a. Facility Name *(If not institution, give street and number)*: CARROLL COUNTY GENERAL HOSPITAL
4b. City, Town, or Location of Death: WESTIMINSTER
4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: 213-30-6420
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 66 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: SEP 24,1934
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: CARROLL
10c. City, Town or Location: HAMPSTEAD
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 4522 BECKLEYSVILLE ROAD
10f. Zip Code: 21074
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CARPENTER & FARMER
16b. Kind of Business/Industry: CONSTRUCTION & FARMING

17. Father's Name *(First, Middle, Last)*: CLARENCE RILL
18. Mother's Neme *(First, Middle, Maiden Surname)*: HELEN BOWMAN

19a. Informant's Neme/Reletionship *(Type, Print)*: JANET RILL, WIFE
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4522 BECKLEYSVILLE RD, HAMPSTEAD, MD 21074

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, cremetory or other piece)*: TRENTON CEMETERY
Date: 01/31 2001
20c. Location - City or Town, State: UPPERCO, MD

21. Signature of Funeral Service Licensee: Steven W Eline MD0723
22. Name end Address of Facility: ELINE FUNERAL HOME 934 SOUTH MAIN ST, HAMPSTEAD, MD 21074

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart leilure. List only one cause on each line.

Approximete Intervel Between Onset end Death

Immediate Cause (Finel disease or condition resulting in death): e. ACUTE MYOCARDIAL INFARCTION WITH VENTRICULAR ARRHYTHMIA

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last:
b. Due to (or es e consequence of):
c. Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medicat examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner stated.
29b. Signature end title of certifier
29c. License number: D33165
29d. Date signed *(Month, Dey, Year)*: 1/29/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Steven Shaffer 7111 Hanover Pike Hampstead md 21074

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 31 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04274

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLES WILLIAM REYNOLDS

2. Date of Death: Month JANUARY Day 23 Year 2001

3. Time of Death: 0237

4a Facility Name (If not institution, give street and number): KENT & QUEEN ANNES HOSPITAL

4b. City, Town, or Location of Death: CHESTERTOWN

4c. County of Death: KENT

Funeral Director

5. Social Security Number: 218-20-2944

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 2, 1924

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Kent

10c. City, Town or Location: Worton

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street end Number: 25209 Porters Grove Road

10f. Zip Code: 21678

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 7 | College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Mechanic

16b. Kind of Business/Industry: Auto

17. Fether's Neme (First, Middle, Last): James Walter Reynolds

18. Mother's Name (First, Middle, Maiden Surname): Mattie Hatten Muterstaw

19a. Informent's Name/Relationship (Type, Print): Sylvia Edith Reynolds

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 25209 Porters Grove Road, Worton, MD 21678

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Pleca of Disposition (Neme of cemetery, cremetory or other piece): Chester Cemetery

Date: 1/27/2001

20c. Location - City or Town, Stete: Chestertown, MD

21. Signature of Funeral Service Licensee: Kirk J. Helfenbein

22. Name end Address of Fecility: Fellows, Helfenbein & newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Final diseese or condition resulting in deeth)

e. Respiratory failure — 18hours

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in death) Lest

b. Pneumonia

Due to (or es e consequenca of):

c.

Due to (or es a consequenca of):

d.

Part II. **Other signifficant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal failure, Hemo Dialysis, ASCVDz, CVA, HTN

Seizure D/o., Aortic Stenosis, BPH, Afib, COPD

LVH, Necrotic Toes 2° to Emboli

23b. Dtd tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Piece of Death (Check only one): Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner es steted. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, death occurred et the time, date end pleca, end due to the ceuse(s) end manner steted.

29b. Signeture end title of certifier: Neil Stoddard MD

29c. License number: D 50996

29d. Dete signed (Month, Dey, Year): 1/23/01

30. Neme end address of person who completed cause of deeth (Item 23e) (Typa, Print): Neil Stoddard MD 100 Bracon St. Chestertown MD 21620

State Registrar

31. Dete filed (Month, Day, Year): JAN 24 2001

32. Registrar's Signature: Brenda D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

6

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

ADMEND: #24A PER VERBAL RESPONSE G795 3-6-01 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04275

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alfred Wilson Reddish, Jr.

2. Date of Death: Month Feb. Day 1, Year 2001

3. Time of Death: 1810

4a. Facility Name (If not institution, give street and number): The Memorial Hospital

4b. City, Town, or Location of Death: Easton

4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 219-36-5480

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 61 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 3, 1939

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Caroline

10c. City, Town or Location: Ridgely

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 12637 Hog Lot Road

10f. Zip Code: 21660

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No. If Yes, Give Year or Dates: 1962-1962

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Caucasian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 HS Grad. College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Alfred Wilson Reddish, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Dorothy Auzealia White

19a. Informant's Name/Relationship (Type, Print): Rodney N. Reddish/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 174 Knife Box Rd., Harrington, De. 19952

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Capitol Crematory

Date: 2/3/01

20c. Location - City or Town, State: Dover, Delaware

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Gram negative Bacterial Sepsis — 5 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. UremiA — 5 days

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

End Stage Renal Disease

Coronary Artery Disease

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Staff Physician MD

29c. License number: D50328

29d. Date signed (Month, Day, Year): 2/2/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James F. Elmore, M.D., 219 South Washington Street, Easton, Maryland 21601

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001

32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Alfred Reddish

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RKD

01-0486-013

JAMES STEWART

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04276

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month	Dsy	Year	3. Tima of Death
JAMES JEFFREY STEWART	JANUARY	29,	2001	3:20P.M.

4a Facility Neme (If not institution, give street end number)	4b. City, Town, or Location of Death	4c. County of Deeth
1200 BLK.NEW WINDSOR ROAD	NEW WINDSOR	CARROLL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Yaar: Months	Deys	If Undar 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Dey, Year)	9. Birthplece (Stefa or Foreign Country)
214-70-2938	1☐M 2☐F XX	40 Yrs.					Sept. 10, 1960	Maryland

Usuel Residence of Decedent

10e. Sfete	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Carroll	Taneytown	1☐Yas 2☒No XX

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4317 Old Taneytown Road	21787	United States

11. Meritel Status	12. Was Decedent Ever in U,S. Armed Forcas?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuben, Mexican, Puerto Rican, etc.)	14. Rece - American Indien, Bleck, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced XX	1☐Yes 2☒No XX If Yes, Give Yeer or Detes:	1☐Yes 2☒No X Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
12		Coordinator	Telecommunications

17. Father's Neme (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surneme)
William Harry Stewart	Mary Ann Kocik

19a. Informent's Name/Reletionship (Type, Print)	19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)
Lynn Stewart/ex-wife	751 Johahn Drive, WEstminster, MD 21158

20a. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
1☐Buriel 2☒Cremetion 3☐Removel from State 4☐Donefion 5☐Other (Specify)	Carroll Cremation	2001 1/31	Hampstead, MD

21. Signature of Funeral Service Licansee	22. Name and Address of Fecility
Robert A. Myers	Myers Funeral Home 91 Willis Street Westminster, MD 21157

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one cause on eech line. — Approximete Interval Between Onset end Death

Immediate Cause (Finel diseese or condition resulting in deeth)
e. Contact Cerebral Hemorrhage of Head

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseasa or Injury thet initieted events resulting in deeth) Last
b.

Due to (or es e consequenca of):
c.

Dua fo (or es e consequenca of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

23b. **Did tobacco use contributa to the cause of death?** 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Wes an autopsy performed?	24b. Were eutopsy findings aveilable prior to completion of cause of deeth?
1☒Yes 2☐No X	1☒Yes 2☐No X

25. Wes case referred to medical examiner?	26. Piece of Deeth (Check only one)	
1☒Yes 2☐No X	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residenca 6☒Other (Specify) SCENE X

27. Menner of Deeth	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Neturel 2☐Accident 3☒Suicide 4☐Homicide XX 5☐Pending investigetion 6☐Could not be determined	1/29/01	Unk M	1☐Yes 2☒No X	Subject shot self

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Parking Lot

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 1200 Blk. New Windsor Rd

29e. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end placa, end due to the cause(s) end menner es steted. 2☒ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred ef the time, date end pleca, end due fo the cause(s) and menner steted. X

29b. Signatura and titla of certifier	29c. Licanse number	29d. Date signed (Month, Day, Year)
John Colorado MD	O.C.M.E.	JANUARY 30, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)
John Colorado MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Dey, Year)	32. Registrer's Signeture
FEB 02 2001	Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Amended, Item#31 (per TCHD) 01/29/01 sbb
Amended, item#2 (per M.D.) 2/12/01, sbb
Amended, Item#30, (per TCHD) 01/29/01 sbb

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04277

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Virginia Mae Skinner

2. Date of Death: Month January Day 25 Year ~~2000~~ 2001

3. Time of Death: 0955

4a. Facility Name (If not institution, give street and number): The Memorial Hospital

4b. City, Town, or Location of Death: Easton

4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 215 16 8609

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 03 22 22

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Talbot

10c. City, Town or Location: Easton

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 412 Glenwood Ave.

10f. Zip Code: 21601

10g. Citizen of What Country?: U.S.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Dosmestic Eng

16b. Kind of Business/Industry: LAbor

17. Father's Name (First, Middle, Last): Juluis Jackson

18. Mother's Name (First, Middle, Maiden Surname): Sarah Jackson

19a. Informant's Name/Relationship (Type, Print): Darcel Skinner (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 412 Glenwood Ave. Easton, Md. 21601

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Stevens

Date: 2-1-2001

20c. Location - City or Town, State: Easton Md 21601

21. Signature of Funeral Service Licensee: Eric L. Dashiell

22. Name and Address of Facility: 322 East Ave. Easton, Md. 21601

Physician /Medical Examiner

23a. Part I. Enter the diseasa, or complications that caused tha death. Do not entar the mode of dying, such es cardiac or respiretory errest, shock, or haart failura. List only ona ceuse on eech lina.

Approximate Interval Between Onset and Death

Immediate Cause (Final disaasa or condition resulting in deeth)

a. Intracerebral Hemorhage — Due to (or es e consequenca of): — 1 Day

Sequentially list conditions, if eny, laading to immediete cause. Enter Underlying Causa (Disease or Injury that initieted events resulting in death) Last

b. HyperRtension — Due to (or es e consequanca of): — Years

c. — Due to (or as e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes en autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings aveilable prior to completion of causa of deeth? 1 ☐ Yes 2 ☐ No

25. Was casa rafarred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Deeth (Check only ona)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify)

27. Mannar of Death: 1 ☒ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Panding investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, deta and plece, end due to tha cause(s) and mennar as stated. 2 ☐ **Medical Examiner:** On tha basis of examinetion and/or invastigation, in my opinion, daath occurred at tha time, data and place, and dua to tha ceuse(s) and manner steted.

29b. Signatura and title of certifier: Carolyn Helmly MD

29c. License number: D0053602

29d. Date signed (Month, Day, Year): 1/26/01

30. Neme and address of person who completed causa of deeth (Item 23e) (Type, Print): ~~Carolyn Helmly, MD~~ Carolyn Helmly, MD 606 Dutchman Lane Easton, Md.

State Registrar

31. Dete filed (Month, Day, Year): JAN 29 2001

32. Registrar's Signature: Penny P. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Virginia Skinner
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

SBB

01-0704-510
CJ
Ian Stewart

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEMS# 23a,b,27& 28a-f G792-021501F SSS per ME

Certificate of Death

Reg. No. 2001 04278

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Data of Death Month	Day	Year	3. Time of Death
IAN	STEWART		February	07	2001	06:39 P.M

4e. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Harbor Hospital Center	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Yaar)	9. Birthplace (State or Foraign Country)
485-46-2518	1☒M 2☐F	58 Yrs.			7/18/1942	IOWA

Usual Residenca of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Insida City Limits
MD.	BALTIMORE	RANDALLSTOWN	1☐Yas 2☒No

10e. Street and Numbar	10f. Zip Coda	10g. Citizan of What Country?
3704 ½ LABURMAN RD.	21133	USA.

11. Marital Stetus	12. Wes Decedant Evar in U.S. Armed Forcas?	13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.)	14. Raca - Amarican Indian, Black, White, etc.
1☐Navar Married 2☐Married 3☐Widowed 4☒Divorced	1☒Yes 2☐No If Yes, Giva Year or Dates: 1959 1963	1☐Yas 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired)	16b. Kind of Businass/Industry
Etamentary/Secondary (0-12)	Coltega (1-4or 5+)		
12		MANAGER	WAREHOUSE

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ALEX STEWART	THELMA BROWN

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Coda)
CHRISTOPHER STEWART -SON	505 CROSSBRIDGE DR., WESTMINSTER, MD.21158

20a. Mathod of Disposition	20b. Place of Disposition (Nama of camatery, cramatory or othar placa)	Data	20c. Location - City or Town, Steta
1☐Burial 2☒Cramation 3☐Removat from Stata 4☐Donation 5☐Other (Specify)	METRO CREMATORY	2/10/01	BALTIMORE, MD.

21. Signatura of Funeral Servica Licansa: ▶ R Lamy Hutchinson

22. Nama and Addrass of Facility: FLETCHER FUNERAL HOME 254 E. MAIN ST.,WESTMINSTER, MD. 21157

Physician /Medical Examiner

23a. Part1. Enter tha diseasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach line.

Approximata Intarval Batwaan Onsat and Daath

Immediata Causa (Finat diseese or condition resulting in daath)

a. CARDIAC ARRHYTHMIA

Dua to (or as a consequanca of):

Sequantially list conditions, if eny, leading to immediete causa. Entar Undarlying Causa (Disaase or injury that initiated events resulting in death) Last

b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE FOLLOWING A VERBAL ALTERCATION

Dua to (or as a consequanca of):

c.

Dua to (or as a consequance of):

d.

IF FEMALE: 23b. Was decedent pregnant in tha past 12 months?	23c. If yas, outcoma of pragnancy	23d. Data of dativary Month / Day / Year
1☐Yas 2☒No 9☐Unknown	1☐Liva birth 2☐Fetel daath 3☐Ectopic pregnancy 4☐Pragnant at tima of death 5☐Other (specify) 9☐Unknown	

Part II. **Dthar significant conditions** contributing to daath but not rasulting in tha undarlying causa givan in Part I.

23a. Did tobacco usa contributa to tha causa of daath? 1☐Yas 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Wara autopsy findings available prior to completion of causa of death?
1☒Yas 2☐No	1☒Yas 2☐No

25. Was casa rafarred to madical examinar?	26. Ptaca of Daath (Chack only ona)	
1☒Yas 2☐No	Hospital: 1☐Inpatiant 2☒ER/Outpatient 3☐DOA	Othar: 4☐Nursing Homa 5☐Rasidanca 6☐Othar (Specify)

27. Manner of Death	28a. Data of Injury (Month, Day Yaar)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurrad
1☐Naturel 2☐Accidant 3☐Suicida 4☐Homicida 5☐Panding invastigation 6☒Could not ba datarmined	2-7-01	unknown M	1☒Yas 2☐No	unknown

28a. Placa of Injury - At homa, farm, straat, factory, offica building, etc. (Specify)	28f. Location (Straat and Numbar or Rural Routa Numbar, City or Town, State)
warehouse	26 E. Ordinance Rd, Balt, MD

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To tha bast of my knowledge, daath occurrad at the time, data and placa, and dua to tha cause(s) and mannar as stated.
2☒ **Medical Examinar:** On tha basis of examination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha cause(s) and mannar stated.

29b. Signatura and title of cartifiar	29c. Licansa number	29d. Data signed (Month, Day, Yaar)
▶ Dennis J Chutcm	O.C.M.E.	February 8, 2001

30. Nama and addrass of parson who comptatad causa of daath (Item 23a) (Typa, Print)
Dennis Chutcms 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Yaar)	32. Registrar's Signatura
FEB 12 2001	▶ Denise G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04279

SLYE, JAMES

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES MAURICE SLYE
2. Date of Death (Month, Day, Year): Feb 01 2001
3. Time of Death: 10:07 AM
4a. Facility Name (If not institution, give street and number): Civista Medical Center
4b. City, Town, or Location of Death: LaPlata
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 212-66-7443
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 49 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPT. 26, 1951
9. Birthplace (State or Foreign Country): MARYLAND

Usuet Residence of Decedent

10a. State: MARYLAND
10b. County: CHARLES
10c. City, Town or Location: NEWBURG
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 12184 MAIDEN POINT FARM
10f. Zip Code: 20664
10g. Citizen of What Country?: UNITED STATES
11. Meritel Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: BLACK
15. Decedent's Eduction (Specify only highest grade completed): Elementery/Secondery (0-12): 12TH GRADE; College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): GROUNDSKEEPER
16b. Kind of Business/Industry: FEDERAL GOVERNMENT
17. Father's Neme (First, Middle, Last): JAMES GILBERT SLYE
18. Mother's Name (First, Middle, Maiden Surname): MILDRED LOUISE THOMAS SLYE
19a. Informent's Neme/Relationship (Type, Print): MILDRED L. SLYE / MOTHER
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14415 ROCK POINT ROAD, NEWBURG, MARYLAND 20664
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from Stete 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): HOLY GHOST CHURCH CEMETERY
Date: 2/6/01
20c. Location - City or Town, Stete: ISSUE, MARYLAND
21. Signature of Funeral Service Licensee: Lydia C. Thornton Johnson
LYDIA C. THORNTON JOHNSON M00583
22. Name end Address of Fecility: THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart feilure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediate Ceuse (Finel diseese or condition resulting in deeth)
a. Polymyositis — 3yrs

Due to (or as a consequence of):
b. Congestive Heart Failure

Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest

Due to (or as e consequence of):
c. Pulmonary Hypertension

Due to (or as e consequence of):
d. Essential Hypertension

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Chronic pleural effusion. Pneumonia. Lymes Disease Synovitis

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 1 [ ] Yes 2 [ ] No

25. Wes cese referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Menner of Deeth: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) and menner steted.
29b. Signature and title of certifier: Paul E. Pritchett, MD
29c. License number: D-0008370
29d. Date signed (Month, Day, Year): 2/1/2001
30. Name and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): Paul E Pritchett, MD 118 LaGrange Ave P O Box 1317 LaPlata MD 20646

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001
32. Registrer's Signeture: Jenna G. Sparks

To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours after deeth.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

ORIGINAL

RKD

01-0362-033
01-019
Charles Frank Streater

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04280

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Charles Frank Streater, Jr.
2. Date of Death Month: JANUARY Day: 22. Year: 2001
3. Time of Death: 11:40A.M.
4a. Facility Name *(If not institution, give street and number)*: 1213 BOONES HILLS ROAD
4b. City, Town, or Location of Death: DISTRICT HEIGHTS
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 577-04-5685
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 20 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 14, 1980
9. Birthplace *(State or Foreign Country)*: Wash., D.C.

Usual Residence of Decedent

10a. State: District of Columbia
10b. County:
10c. City, Town or Location: Washington
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3827 First St., S.E. #2
10f. Zip Code: 20032
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11th; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Construction Worker
16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: Charles Frank Streater, Sr.
18. Mother's Name *(First, Middle, Maiden Surname)*: Mechelle Jackson

19a. Informant's Name/Relationship *(Type, Print)*: Valinda Streater - Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3827 First St., S.E. #2, Wash., D.C. 20032

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Ft. Lincoln Cemetery
Date: 1/29/2001
20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: John T. Stewart, III
22. Name and Address of Facility: Stewart Funeral Home, 4001 Benning Rd., N.E. Wash., D.C. 20019

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Gunshot Wounds (2) of Head (1) and Back (1)

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* SCENE

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day, Year)*: Found 1/22/01
28b. Time of Injury: 1125 HR
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: gunshot
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: behind building
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 1313 Boones Hill Road Capitol Heights Maryland

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Theodore M. King MD
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: JANUARY 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. KING, 111 Penn Street, Baltimore, Maryland 21201

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(2)

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

01-0487-510
CJ
Margaret Schofield

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04281

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret H. Schofield
2. Date of Death: Month: January; Day: 29; Year: 2001
3. Time of Death: 05:22 P.M.
4a. Facility Name (If not institution, give street and number): 3436 Mayfield Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-03-4122
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 5, 1911
9. Birthplace (State or Foreign Country): Pittsburgh

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3436 Mayfield Avenue
10f. Zip Code: 21213
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerical/Bookkeeper
16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): John Harris
18. Mother's Name (First, Middle, Maiden Surname): Annie Gilston

19a. Informant's Name/Relationship (Type, Print): John F. Monath (Executor)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2902 Manns Ave., Parkville, Maryland 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith
Date: 2/2/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Hypertensive Arteriosclerotic Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. X
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Scene

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): January 30, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TIMOTHON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 1 2001
32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-0715-510
mnmr
Thomas Thrappas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED# 23a,b,27 per ME G793 031901 SS

Certificate of Death

Reg. No. 2001 04282

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Thomas Steve Thrappas	February 08, 2001	910 a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St. Agnes Hospital	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-70-4420	1☒M 2☐F	35 Yrs.			Sept. 23, 1965	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Harford	Joppa	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11 Fort Hoyle Road	21085	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Steelworker	Steel Manufacturer

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Sumeme)
Nicholas Daniel Thrappas	Patricia Ann Bielecki

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Sandra Kay Thrappas/Wife	11 Fort Hoyle Road, Joppa, MD 21085

20a. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, Stete
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Holly Hill Mem.	2/10/01	Baltimore, MD

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name end Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, MD 21009

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CARDIAC ARRHYTHMIA DUE TO	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. MYOCARDIAL HYPERTROPHY IN ASSOCIATION WITH ATHEROSCLEROTIC CARDIOVASCULAR DISEASE	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnancy 4☐Pregnant at time of deeth 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probebly 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined			1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] M.D.	O.C.M.E.	February 09, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARY C. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 15 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04283

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EVA I. TOYE
2. Date of Death: Month 01 Day 27 Year 2001
3. Time of Death: 2 30 p.m.
4a. Facility Name (If not institution, give street and number): Gladys Spellman Specialty Hospital
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 218-14-2052
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): February, 18, 1924
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Charles
10c. City, Town or Location: Hughesville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 16740 Prince Frederick Rd.
10f. Zip Code: 20637
10g. Citizen of What Country?: U.S.A
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates: X
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify: X
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Restaurateur
16b. Kind of Business/Industry: Toye's Inn
17. Father's Name (First, Middle, Last): John Mitchell
18. Mother's Name (First, Middle, Maiden Surname): Isabella Bulter
19a. Informant's Name/Relationship (Type, Print): Mary Templeman / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2372 Hazlewood Ct. Waldorf, Maryland 20601
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Veterans Cem.
Date: 2/06/01
20c. Location - City or Town, State: Cheltenham, MD.
21. Signature of Funeral Service Licensee: Lloyd E[illegible] M 1911
22. Name and Address of Facility: Adams Funeral Home P.A.. Aquasco, MD 20608

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Ischemic bowel	2 months
Due to (or as a consequence of): b.	Arteriosclerotic cardiovascular disease	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure

Sepsis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] / attending, internal medicine
29c. License number: D0056420
29d. Date signed (Month, Day, Year): 1/28/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Peter Wagner, 9304 Cherry Hill Rd #103, College Park, MD 20740

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04284

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Eleanor Marietta Tobie

2. Date of Death (Month, Day, Year): January 24, 2001

3. Time of Death: 1:15 p.m.

4e. Facility Name *(If not institution, give street and number)*: Heron Point

4b. City, Town, or Location of Death: Chestertown

4c. County of Death: Kent

Funeral Director

5. Social Security Number: 484-22-1795

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 92 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: November 11, 1908

9. Birthplace *(State or Foreign Country)*: Latimore, Iowa

Usual Residence of Decedent

10a. State: Maryland

10b. County: Kent

10c. City, Town or Location: Chestertown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 233 Heron Point

10f. Zip Code: 21620

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 8

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Parasitology

16b. Kind of Business/Industry: Health Care/Research

17. Father's Name *(First, Middle, Last)*: Albert Johnson

18. Mother's Name *(First, Middle, Maiden Surname)*: Marie Laura Schonemann

19e. Informant's Name/Relationship *(Type, Print)*: Sarah Brash

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 806 Carroll Street, Brooklyn, NY 11215

20e. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Cremation Center, LLC — Date: 1/26/01

20c. Location - City or Town, State: Stevensville, Maryland

21. Signature of Funeral Service Licensee: Kirk A Helfenbein

22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. BRAIN TUMOR - MALIGNANT — 6 mo.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Helen A Noble MD

29c. License number: D0041587

29d. Date signed *(Month, Day, Year)*: 1/25/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Helen A. Noble, 122 Speer Road, Chestertown, Maryland 21620

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 26 2001

32. Registrar's Signature: Brenda D. Hyatt

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04285

Amend #8, 12, 1/26/2001, EMW, Montg. Co.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Vincent W. Thomas	January 14, 2001	10:30 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Washington Adventist Hospital	Takoma Park	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-64-4917	1 [X] M 2 [ ] F	85 Yrs.			June 12, ~~1915~~ 1917	Washington, D.C.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
N/A	N/A	Washington, D.C.	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5260 Chillum Place, N.E.	20011	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: ~~1945-1949~~ '42-'45	1 [ ] Yes 2 [X] No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	N/A	N/A

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Phillip Walker Thomas	Evelyn V. Lewis

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Alice Thomas Sister-in-law	5260 Chillum Place, N.E., Washington, D.C. 20011

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Chesapeake Crematory	1-17-01	Beltsville, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
[signature]	McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. 20012

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Ischemic Bowel with sepsis	6 week
Due to (or as a consequence of):	b. Acute Renal Failure	1 wk.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of):	c.	
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	D21900	January 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smith Ho 1610 Carroll Ave. #250 Takoma Park Md. 20912

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 22 2001	[signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04286

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George Joseph Dwight Webb

2. Date of Death: Month January Day 28 Year 2001

3. Time of Death: 8:30pm

4a. Facility Name (If not institution, give street and number): 4701 Marriottsville Road #2

4b. City, Town, or Location of Death: Sykesville

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 237-34-2948

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept 8 1926

9. Birthplace (State or Foreign Country): N.C.

Usual Residence of Decedent

10a. State: Md

10b. County: Carroll

10c. City, Town or Location: Sykesville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4701 Marriottsville Road #2

10f. Zip Code: 21784

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): flagger

16b. Kind of Business/Industry: road construction

17. Father's Name (First, Middle, Last): Craig Webb

18. Mother's Name (First, Middle, Maiden Surname): Launa Lee

19a. Informant's Name/Relationship (Type, Print): Susan D. VanGerpen (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 203 East 10th St., Kearney, Missouri 64030

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): All County Cremation Ser.

Date: 1-30-01

20c. Location - City or Town, State: Sykesville, Md

21. Signature of Funeral Service Licensee: ▶ Paige Haight Herbert

22. Name and Address of Facility: Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md 21784

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sudden Cardiac Death

Due to (or as a consequence of):

b. Coronary Heart Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

Diabetes Mellitus, type II

Hypertension, Hypercholesterolemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Gary A Manko MD

29c. License number: D2862

29d. Date signed (Month, Day, Year): 1/29/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GARY A MANKO, MD, 730 MAIN Street, Reisterstown, MD 21136

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001

32. Registrar's Signature: ▶ D Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

01-0622-005

CARLI WEICHERT
ASP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEM 1,23a,b,& 27 per ME G794 047401 SS

Certificate of Death

Reg. No. 2001 04287

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

State Registrar

1. Decedent's Name (First, Middle, Last): Carli Rae Wiechert
2. Date of Death (Month, Day, Year): FEBRUARY 05 2001
3. Time of Death: 0540 M
4a. Facility Name (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL
4b. City, Town, or Location of Death: ESSEX
4c. County of Death: BALTIMORE
5. Social Security Number: 212-59-3075
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 0 Yrs.
If Under 1 Year: Months 6 Days 2
If Under 24 Hrs.: Hours Min.
8. Date of Birth (Month, Day, Year): Aug. 3, 2000
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Perry Hall
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 29 Offspring Ct.
10f. Zip Code: 21128
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Reca - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 0
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Infant
16b. Kind of Business/Industry: Infant

17. Father's Name (First, Middle, Last): Adrian J. Wiechert, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Shelley Rae Gach

19a. Informant's Name/Relationship (Type, Print): Mrs. Shelley Wiechert (mother)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 29 Offspring Ct., Perry Hall, MD 21128

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Parkwood Cemetery
Date: 2/9/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ATRIOVENTRICULAR SEPTAL DEFECT OF HEART
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. DOWN'S SYNDROME
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] M.D
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): FEBRUARY 06, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year): FEB 14 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04288

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Jala Waller
2. Date of Death Month Day Yaar: Feb. 06, 2001
3. Time of Death: 08:53 p.m.

4a Facility Name *(If not institution, give street and number)*: Washington Adventist Hospital
4b. City, Town, or Location of Deeth: Takoma Park
4c. County of Deeth: Montgomery

Funeral Director

5. Social Security Number: N/A
6. Sex: 1☐ M 2☒ F
7. Aga *(In yrs. last birthday)* Yrs.: If Under 1 Year Months / Days; If Under 24 Hrs. Hours / Min.: 10
8. Date of Birth *(Month, Day, Year)*: Feb. 06, 2001
9. Birthplaca *(State or Foreign Country)*: Maryland

Usual Rasidence of Decedant

10a. Steta: MD
10b. County: Prince Georges
10c. City, Town or Location: Hyattsville
10d. Insida City Limits: 1☒ Yas 2☐ No
10e. Street and Number: 3601 Gallatin Street, #712
10f. Zip Code: 20782
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Navar Married 2☐ Married 3☐ Widowad 4☐ Divorcad
12. Was Decedant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*
14. Raca - Amarican Indian, Black, White, atc. *Specify:* Black

15. Decedant's Education *(Specify only highest grada completed)*: Elementary/Secondary (0-12): N/A; Collega (1-4or 5+): N/A
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use ratirad)*: N/A
16b. Kind of Businass/Industry: N/A

17. Fathar's Nama *(First, Middle, Last)*: Unknown
18. Mothar's Nama *(First, Middle, Maidan Surnama)*: Michelle D. Waller

19a. Informant's Neme/Ralationship *(Type, Print)*: Suseela Drumheller, Birth Registrar
19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 7600 Carroll Ave., Takoma Park, MD 20912

20a. Mathod of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Placa of Disposition *(Nama of cematary, cramatory or othar placa)*: Wash. Advent. Hospital
Date: 2001
20c. Location - City or Town, Stata: Takoma Park, MD

21. Signatura of Funaral Sarvica Licensaa: Margie L Jacobs
22. Nama and Addrass of Facility: Washington Adventist Hospital 7600 Carroll Ave., Takoma Park, MD 20912

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the diseasa, or complications that caused the death. Do not antar the moda of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only ona causa on aach lina.

Approximata Intarval Batween Onsat and Death

Immediata Causa (Final diseasa or condition resulting in daath)
a. Extreme Prematurity (385 grams) 21 weeks
Dua to (or as a consaquance of):
b. Pulmonary failure
Dua to (or as a consaquanca of):
Sequentially list conditions, if eny, laading to immadiata causa. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. Preterm delivery at about 21 wks
Dua to (or as a consaquanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa givan in Part I.

23b. Did **tobacco usa contribute to the causa of death?** 1☐ Yas 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Were autopsy findings available prior to complation of causa of daath? 1☐ Yas 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

25. Was casa refarrad to medical examinar? 1☐ Yas 2☒ No
26. Placa of Daath *(Chack only ona)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Othar: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Othar *(Specify)*
27. Mannar of Daath: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined
28a. Data of Injury *(Month, Day Yaar)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar stated.
29b. Signatura and title of certifiar: ~etino
29c. Licansa number: 54561
29d. Data signad *(Month, Day, Yaar)*: 2/8/01

30. Nama and addrass of parson who completed causa of daath (Item 23a) (Type, Print): Staff OB of Washington Adventist Hospital
Kathy M. Mahalati, M.D. 7600 Carroll Ave., Takoma Park, MD 20912

State Registrar

31. Data filed *(Month, Day, Yaar)*: FEB 14 2001
32. Registrar's Signature: Renee G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ADMEND ITEM: #27 PER PHY G794 4-2-01 WR. *Certificate of Death*

Reg. No. 2001 04289

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Gladys Anna White
2. Date of Death Month / Day / Year: January 30, 2001
3. Time of Death: 2:20PM
4a. Facility Name *(If not institution, give street and number)*: Laurel Regional Hospital
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 213-01-7607
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 17, 1912
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Howard
10c. City, Town or Location: Savage
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 8523 Howard Street
10f. Zip Code: 20763
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9 | College (1-4or 5+): Ø
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Charles R.J. White
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Elizabeth Fisher

19a. Informant's Name/Relationship *(Type, Print)*: Mary DuMond/Sister
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8523 Howard Street, Savage, MD 20763

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory, Inc.
Date: 1/31/01
20c. Location - City or Town, State: Catonsville, MD

21. Signature of Funeral Service Licensee: [signature] M00160
22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Sepsis
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. CVA
Due to (or as a consequence of):
c. Dehydration
Due to (or as a consequence of):
d. Renal Failure

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD Attending
29c. License number: D42580
29d. Date signed *(Month, Day, Year)*: January 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PS. Aujla, MD 5632 Annapolis Road # 13, Bladensburg, MD 20710

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 01 2001
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

HOWARD

27

13 days

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04290

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOHN D WELLS
2. Date of Death — Month: 01 Day: 20 Year: 2001
3. Time of Death: 07:55 AM
4a. Facility Name *(If not institution, give street and number)*: HOLY CROSS HOSPITAL
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 557-18-3519
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 76 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: OCT. 8, 1924
9. Birthplace *(State or Foreign Country)*: CALIFORNIA

Usual Residence of Decedent

10a. State: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 607 VALLEY BROOK DR.
10f. Zip Code: 20904
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1943-1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): ; College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: RET.- CONSULTANT
16b. Kind of Business/Industry: ECONOMICS AND STATISTICS

17. Father's Name *(First, Middle, Last)*: MAURICE WELLS
18. Mother's Name *(First, Middle, Meiden Sumeme)*: EDITH HAINES

19a. Informent's Neme/Reletionship *(Type, Print)*: WILLIAM N. WELLS/SON
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 9704 CEDAR LA., BETHESDA, MD. 20814

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Pleca of Disposition *(Neme of cemetery, cremetory or other piece)*: CHAMBERS CREMATORY — Dete: 1/22/01
20c. Location - City or Town, Stete: RIVERDALE, MD.

21. Signature of Funerel Service Licensee: W. W. Chambers M00091
22. Name and Address of Facility: CHAMBERS FUNERAL HOMES, P.A., 5801 CLEVELAND AVE. RIVERDALE, MD. 20737

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one cause on eech line. — Approximeta Intervel Between Onset end Deeth

Immediate Cause (Finel disease or condition resulting in deeth): e. Gram positive cocci bacteremia from leg ulcer — 6 days

Due to (or es a consequenca of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Lest:
b.
Due to (or es e consequence of):
c.
Due to (or es e consequenca ot):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: chronic atrial fibrillation; type 2 diabetes mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveilable prior to completion of cause ot deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Mennar of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end manner es stated. 2☐ **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, deeth occurred et the time, date end placa, and due to the ceuse(s) end menner steted.

29b. Signature and title of certifier: Robert H Gerard MD
29c. License number: D0055522
29d. Date signed *(Month, Day, Year)*: 01/20/01

30. Nema and addrass of person who completed causa of death (Item 23a) (Type, Print): ROBERT H GERARD MD 1500 FOREST GLEN RD SILVER SPRING, MD KAISER PERM.

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 23 2001
32. Registrar's Signetura: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04291

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gary Lee Anders Sr.
2. Data of Death (Month, Day, Year): February 13, 2001
3. Tima of Death: 11:55Am
4a Facility Nema (If not institution, give street and number): Good Samaritan Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-82-2772
6. Sax: 1☒M 2☐F
7. Aga (In yrs. last birthday): 41 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): 6-12-1959
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedant

10a. Stata: MD
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Insida City Limits: 1☒Yas 2☐No
10e. Street and Number: 1030 Iris Avenue
10f. Zip Coda: 21205
10g. Citizen of What Country?: USA

11. Maritaf Status: 1☐ Nevar Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedant Evar in U.S. Armad Forcas? 1☒Yas 2☐No If Yas, Giva Yaar or Datas: Army
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:
14. Race - American Indian, Black, Whita, atc. Specify: WHite
15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 12th; Collega (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired): Machine operator
16b. Kind of Businass/Industry: Box Company
17. Father's Name (First, Middle, Last): Charles E. Anders Sr.
18. Mother's Nama (First, Middle, Maiden Sumame): Margaret Wise
19a. Informant's Name/Reletionship (Type, Print): Gary Lee Anders Jr.
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 1030 Iris Ave.,Baltimore, Maryland 21205
20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Name of cametary, crematory or other placa): Garrison Forest — Data: 2/16601
20c. Location - City or Town, Stete: Baltimore, Maryland
21. Signature of Funaral Service Licensee: ▶ Marea B. Zannino
22. Name end Address of Facility: Joseph N. Zannino Jr. Funeral Hm 263 S. Conkling St., Baltimore, Maryland 21224

Physician Medical Examiner

23a. Part1. Entar tha disaase, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only one causa on aach lina.

		Approximata Intarval Batween Onsat end Deeth
Immediata Causa (Final disease or condition resulting in death) a.	Cardiac Arrest	45mins
Dua to (or as a consequance of): b.	Cauda Equina Syndrome	3weeks
Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Diseasa or injury that initiated evants resulting in death) Last — Dua to (or es a consequance of): c.	lumbar laminectomy	one week
d.		

Part II. **Other significant conditions** contributing to death but nof rasulting in fhe undarlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings availabla prior to completion of causa of death? 1☐ Yas 2☐ No

25. Was casa rafarred to medical axaminar? 1☐ Yas 2☒ No

26. Placa of Daath (Check only one): Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and place, and due to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha cause(s) and menner stated.

29b. Signatura and title of cartifier: ▶
29c. License number: D47474
29d. Data signad (Month, Day, Year): February 13, 2001

30. Name end addrass of parson who complatad causa of daath (Item 23a) (Type, Print): Lyng-Ling Cheng M.D. Good Samaritan Hospital, 5601 Loch Raven Blvd. Baltimre MD 21239

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001
32. Registrar's Signatura: ▶ penning D. Sparks

MH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04292

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ROBERT L ARCHER

2. Date of Death: Month 02 Day 13 Year 01

3. Time of Death: 8:53am

4a. Facility Name *(If not institution, give street and number)*: BALTIMORE VA MEDICAL CENTER

4b. City, Town, or Location of Death: BALTIMORE, MD

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 214-12-0908

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 11/17/1919

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 490 Brunswick Street

10f. Zip Code: 21223

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: 1944-44

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Dock worker

16b. Kind of Business/Industry: Longshorman

17. Father's Name *(First, Middle, Last)*: William A. Archer

18. Mother's Name *(First, Middle, Maiden Surname)*: Nora S. Almony

19a. Informant's Name/Relationship *(Type, Print)*: Belinda Miller/daughter in law

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 45 Wengate Road Owings Mills, Maryland 21117

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Good Shepherd Cemetery

Date: 2/16/01

20c. Location - City or Town, State: Ellicott City, Md.

21. Signature of Funeral Service Licensee: David J. Weber

22. Name and Address of Facility: David J. Weber Funeral Homes, P.A. 5311 Edmondson Avenue Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE	5 years
Due to (or as a consequence of):	b. ATRIAL FIBRILLATION	3 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gwynn C Schoonmaker MD

29c. License number: A41764355 13143

29d. Date signed *(Month, Day, Year)*: 2/13/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gwynn Schoonmaker 10 N. Greene St. Baltimore MD 21201

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 15 2001

32. Registrar's Signature: Regina B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04293

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Louis E. Butler

2. Date of Death (Month, Day, Year): 02 10 2001

3. Time of Death: 5:12a.m.

4a. Facility Name (If not institution, give street and number): Joseph Richey Hospice

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 219-12-4063

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 08 09 20

9. Birthplace (State or Foreign Country): M.D.

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2504 Francis Street

10f. Zip Code: 21217

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 6th grade

College (1-4or 5+): na

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cook

16b. Kind of Business/Industry: Leon's Pig Pen

17. Father's Name (First, Middle, Last): Shaft Butler

18. Mother's Name (First, Middle, Maiden Surname): Mary Elizabeth Cole

19a. Informant's Name/Relationship (Type, Print): Mary H. Butler-Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2504 Francis Street, Baltimore Md 21217

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Western Star Cemet. Date: 2/16/01

20c. Location - City or Town, State: Baltimore, Md

21. Signature of Funeral Service Licensee: Teresa G Butler

22. Name and Address of Facility: March F/H West, 4300 Wabash Ave, Baltimore Md 21215

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic cancer prostate — years

Due to (or as a consequence of):

b. Renal failure — 1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
Hyperlipidemia
GI bleeding / anemia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Richey hospice

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: T. Powell M.D.

29c. License number: D 13006

29d. Date signed (Month, Day, Year): 2/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Thomas Powell, 101 W. Read St, 21201

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04294

PATIENT KNOWN AS: EDWARD A. BARBOUR [FAMILY STATES LEGAL NAME IS EDWARD A. BARBER]

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward Barber, Jr. AKA Edward Alexander Barbour
2. Date of Death (Month, Dey, Year): FEBRUARY 13, 2001
3. Time of Death: 22:18
4a. Facility Neme (If not Institution, give street end number): SINAI HOSPITAL OF BALTIMORE
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Deeth: N/A

Funeral Director

5. Social Security Number: 103-46-9840
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthdey): 45 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): NOV 9, 1955
9. Birthplece (Stete or Foreign Country): New York

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Baltimore
10c. City, Town or Location: Windsor Mills
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 2402 Battersea Place Apt 203
10f. Zip Code: 21244
10g. Citizen of Whet Country?: USA

11. Meritel Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondery (0-12): / College (1-4or 5+): 4
16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired): Assistant Director
16b. Kind of Business/Industry: Non-Profit Organization

17. Father's Neme (First, Middle, Last): Edward Barber, Sr.
18. Mother's Name (First, Middle, Maiden Sumeme): Christine Atkins

19a. Informent's Neme/Relationship (Type, Print): Christine Barber/Mother
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1050 Bedford Avenue Brooklyn, NY 11205

20e. Method of Disposition: 1 [ ] Burial 2 [X] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Metro Crematory Inc.
Dete: 2-15-01
20c. Location - City or Town, Stete: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ Dawn P. McDonald
22. Name end Address of Feciity: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert feiture. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediate Cause (Finel disease or condition resulting in death)
e. LACTIC ACIDOSIS — 5 WEEKS
Due to (or es e consequenca of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Lest
b.
Due to (or es e consequenca of):
c.
Due to (or es e consequence of):
d.

Pert tt. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.
HUMAN IMMUNODEFICIENCY VIRUS, ACQUIRED IMMUNODEFICIENCY SYNDROME

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings eveiteble prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Deeth (Check only one): Hospitel: 1 [X] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined
28a. Dete of Injury (Month, Dey Yeer):
28b. Time of Injury: M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify):
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es stated. 2 [ ] **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner steted.

29b. Signature end title of certifier: ▶ David C. Lott, M.D., PGY-1
29c. License number: RES000
29d. Date signed (Month, Dey, Yeer): FEBRUARY 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID C. LOTT, M.D.
SINAI HOSPITAL, 2401 WEST BELVEDERE AVENUE, BALTIMORE, MARYLAND 21215

State Registrar

31. Dete filed (Month, Dey, Yeer): FEB 15 2001
32. Registrer's Signeture: ▶ B. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04295

Boegner Charles

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Charles N. Boegner
2. Date of Death (Month, Day, Year): Feb 12 2001
3. Time of Death: 5:30AM
4a. Facility Name *(If not institution, give street and number)*: Cromwell Nursing Center
4b. City, Town, or Location of Death: Parkville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-07-4467
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 82 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)
8. Date of Birth *(Month, Day, Year)*: Aug 25 1918
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 2634 Wentworth Rd.
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yas 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): —
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Chief of payroll
16b. Kind of Business/Industry: Bethlehem Steel

17. Father's Name *(First, Middle, Last)*: Joseph M. Boegner
18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret A. Nikol

19a. Informant's Name/Relationship *(Type, Print)*: Carmelita F. Boegner
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2634 Wentworth Rd. Baltimore, Md 21234

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Dulaney Valley Mem Gdns
Date: Feb 15 2001
20c. Location - City or Town, State: Timonium Maryland

21. Signature of Funeral Service Licensee: Krista S Wells
22. Name and Address of Facility: Evans Funeral Chapel 8800 Harford Rd Baltimore, Md 21234

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Acute Renal Failure	days
Due to (or as a consequence of): b.	Obstructive Uropathy	months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Chronic Renal failure	months
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: OA CHF CRI Afibrillation, GERD Urinary Retention. Perinal cystectomy

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yas 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yas 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Martha C. Raymundo MD
29c. License number: 054518
29d. Date signed *(Month, Day, Year)*: 2/14/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Martha C Raymundo 3007 E northern Parkway Baltimore MD 21214

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 15 2001
32. Registrar's Signature: D. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04296

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Rosa E. Brown
2. Dete of Deeth (Month, Dey, Yeer): February 14, 2001
3. Time of Deeth: 3:41 AM
4a Facility Name *(If not institution, give street and number)*: Southern Maryland Hospital Center
4b. City, Town, or Location of Death: Clinton
4c. County of Deeth: Prince Georges

Funeral Director

5. Social Security Number: 579-28-6839
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 86 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Yeer)*: 9-1-14
9. Birthplece *(Stete or Foreign Country)*: Virginia

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Prince Georges
10c. City, Town or Location: Fort Washington
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 109 River Forest Lane
10f. Zip Code: 20744
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - Americen Indien, Bleck, White, etc. *Specify:* Black
15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Home Maker
16b. Kind of Business/Industry: Own Home
17. Father's Neme *(First, Middle, Last)*: Wesley P. Atkins
18. Mother's Name *(First, Middle, Maiden Surneme)*: Pearl Jenkins
19e. Informent's Neme/Reletionship *(Type, Print)*: Rosalie B.Huff Daughter
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 109 River Forest Lane Fort Washington,Md 20744
20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: National Memorial Pk. | Dete: 2/19/01
20c. Location - City or Town, Stete: Mclean,Virginia
21. Signature of Funeral Service Licensee: Robert B Baker Jr.
22. Neme end Address of Facility: Chinn Funeral Service 2605 S.Shirlington Rd.arlington,Va.22206

Physician /Medical Examiner

23e. Part1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one cause on eech line. | Approximete Interval Between Onset and Death

Immediete Ceuse (Finel diseese or condition resulting in deeth)
e. Septic Shock — Unknown
Due to (or as e consequence of):
b. Hypotension — Unknown
Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediete ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last
c. Urinary Tract infection — Unknown
Due to (or es a consequence of):
d. Pneumonia

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28e. Dete of Injury *(Month, Dey Yeer)* | 28b. Time of Injury M | 28c. Injury et Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) and manner stated.
29b. Signature and title of certifier: Ara Yazdani
29c. License number: D50454
29d. Date signed *(Month, Day, Year)*: February, 14, 2001
30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): ARA S+00 YAzdani 9801 Georgia AVE Suite 3-35 Silver SPRINGS MD 20902

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: FEB 15 2001
32. Registrer's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04297

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MSGR. GERARD W. BRODERICK

2. Date of Death — Month: February Day: 14 Year: 2001

3. Time of Death: 1:00 am

4a. Facility Name (If not institution, give street and number): STELLA MARIS NURSING HOME

4b. City, Town, or Location of Death: TIMONIUM

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-46-2007

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 8/5/1916

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: TIMONIUM

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 2300 DULANEY VALLEY ROAD

10f. Zip Code: 21093

10g. Citizen of What Country?: USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4or 5+): 8 YEARS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CLERGY

16b. Kind of Business/Industry: CATHOLIC CHURCH

17. Father's Name (First, Middle, Last): GEORGE BRODERICK

18. Mother's Name (First, Middle, Maiden Surname): ALICE STARKEY

19a. Informant's Neme/Relationship (Type, Print): DORIS H. KENNEDY SISTER

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 323 LEYTON ROAD REISTERSTOWN, MD 21136

20a. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removel from State 4☐Donetion 5☐Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other place): NEW CATHEDRAL CEMETERY — Dete: 2/17/01

20c. Location - City or Town, Stete: BALTIMORE, MD

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Physician /Medical Examiner

23a. PART I. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Intervel Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Head and neck cancer — months

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the causa of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Wes an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one) — Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Menner of Death: 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☐Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) end menner es steted. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ MD

29c. License number: 31550

29d. Date signed (Month, Day, Year): 02.12.01

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): EDDIE NAKHUDA, MD 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093

State Registrar

31. Dete filed (Month, Day, Year): FEB 15 2001

32. Registrar's Signature ▶ G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME: BRODERICK, GERARD

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04298

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Rose Berkey

2. Date of Death — Month: February; Day: 13; Year: 2001

3. Time of Death: 4:23pm

4a. Facility Name *(If not institution, give street end number)*: 4042 St. Augustine Lane

4b. City, Town, or Location of Death: Dundalk

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-24-3095

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 70 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 8-30-1930

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4042 St. Augustine Lane

10f. Zip Code: 21222

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: In own home

17. Father's Name *(First, Middle, Last)*: Louis Hughes

18. Mother's Name *(First, Middle, Maiden Surname)*: Catherine Eder

19a. Informant's Name/Relationship *(Type, Print)*: daughter Gloria Jones

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 3103 Baybriar Rd., Baltimore, Maryland 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Oaklawn

Date: 2/17/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Maria B Zennino

22. Name and Address of Facility: Joseph N. Zannino Jr. Funeral HM 263 S. Conkling St., Baltimore, Maryland 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*: NA

28b. Time of Injury: NA M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: NA

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: NA

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*: NA

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner stated.

29b. Signature end title of certifier: ▶ Ronald Thomas MD

29c. License number: D0026318

29d. Date signed *(Month, Day, Year)*: 2/14/01

30. Name end address of person who completed cause of death (Item 23e) (Type, Print): Ronald E. Thomas, MD 3004 Emmorton Rd, Abingdon, Md. 21009

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 15 2001

32. Registrar's Signature: ▶ B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04299

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mildred Baldwin

2. Date of Death (Month, Day, Year): FEB 09 2001

3. Time of Death: 12 20 p

4a. Facility Name (If not institution, give street and number): Levindale Nursing Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 238-64-9464

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 28, 1940

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1156 N. Calhoun St.

10f. Zip Code: 21217

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse

16b. Kind of Business/Industry: Hospital

17. Father's Name (First, Middle, Last): Shady Cobb

18. Mother's Name (First, Middle, Maiden Surname): Lucille Outlaw

19a. Informant's Name/Relationship (Type, Print): Ms. Gail Bailey (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1156 N. Calhoun St. Balto. Md. 21217

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Mem. Park | Date: 2/15/2001

20c. Location - City or Town, State: Balto. Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ

22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pontine hemorrhage

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Raymond Miller MD

29c. License number: D47683

29d. Date signed (Month, Day, Year): 2/9/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Raymond Miller 25 Main Street Suite 200 Hagerstown MD

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

BALDWIN, MILDRED

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04300

AMEND#7 PER F.H. G792 2-15-2001 JAB

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Deta of Death Month	Day	Year	3. Tima of Death
AUGUSTA		BRITT	FEBRUARY	6	2001	04:10 AM

4a Facility Nama (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Deeth
GOOD SAMARITAN HOSPITAL	BALTIMORE	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex 1☐M 2☑F	7. Aga (In yrs. last birthday)	If Under 1 Yaar Months	Days	If Under 24 Hrs. Hours	Min.	8. Data of Birth (Month, Day, Year)	9. Birthplaca (State or Foreign Country)
245-14-8022		~~78~~ 77 Yrs.					4-23-1923	North Caroline

Usual Rasidance of Decedant

10a. Stata	10b. County	10c. City, Town or Location	10d. Insida City Limits
MD		Baltimore	1☑Yas 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1535 NorthWick	21218	USA

11. Marital Status	12. Was Decedent Evar in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.)	14. Race - American Indian, Black, Whita, atc.
1☐Nevar Married 2☑Married 3☐Widowed 4☐Divorced	1☐Yas 2☑No If Yas, Giva Yaar or Dates:	1☐Yas 2☑No Specify:	Specify: Black

15. Decedant's Educetion (Specify only highast grade completad)		16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elamantary/Secondary (0-12)	Collega (1-4or 5+)		
6th		Presser	Loudon town manuf.

17. Father's Name (First, Middle, Last)	18. Mothar's Nama (First, Middla, Maidan Surnama)
Henry Barbee	melissa Barbee

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Coda)
Joanne Frazier-Daughter	6011 Carter Ave. Baltimore, Maryland 21214

20a. Method of Disposition	20b. Place of Disposition (Nama of cemetery, crematory or othar piece)	Data	20c. Location - City or Town, Stata
1☑Burial 2☐Cremation 3☐Removal from Stata 4☐Donetion 5☐Othar (Specify)	Garrison forest Cemetery	2/12/2001	Baltimore, maryland

21. Signature of Funaral Service Licensee	22. Name and Address of Facility
▶ Geoffrey Miller	Miller's Metropolitan Chapel 1639 N. Broadway 21213

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused tha deeth. Do not antar tha moda of dying, such as cardiac or raspiretory arrest, shock, or heart failure. List only one cause on eech line.

Approximete Intarval Batwaan Onsat and Death

Immediata Causa (Final disaasa or condition rasulting in daath)

a. ACUTE MYOCARDIAL INFARCTION

Dua to (or as e consequance of):

Sequantially list conditions, if any, leading to immediate causa. Entar Undarlying Causa (Disaasa or injury thet initiated evants rasulting in death) Last

b. HYPERTENSION

Dua to (or as a consequance of):

c.

Dua to (or as e consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the undarlying ceuse given in Part I.

DIABETES MELLITUS

MULTI INFARCT DEMENTIA

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Ware autopsy findings availabla prior to completion of ceusa of death?
1☐Yas 2☑No	1☐Yas 2☑No

25. Was cesa refarrad to medicel examinar?	26. Placa of Death (Check only ona)	
1☐Yas 2☑No	Hospital: 1☑Inpatiant 2☐ER/Outpatiant 3☐DOA	Othar: 4☐Nursing Homa 5☐Rasidence 6☐Othar (Specify)

27. Mannar of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicida 4☐Homicida 5☐Pending invastigation 6☐Could not be determined		M	1☐Yas 2☐No	

28e. Placa of Injury - At homa, farm, street, factory, office building, atc. (Spacify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifiar (Check only one)

1☑**Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha cause(s) and manner as stated.

2☐**Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, date and place, and due to tha cause(s) and mannar stated.

29b. Signatura and titla of certifiar	29c. License number	29d. Data signed (Month, Day, Year)
▶ Ron Rosen, MD	RES-P13458	FEBRUARY 6, 2001

30. Name and addrass of person who complated causa of daath (Item 23a) (Type, Print) GOOD SAMARITAN HOSPITAL

RON ROSEN, MD 5601 LOCH RAVEN BOULEVARD, BALTIMORE MARYLAND 21239

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signatura
FEB 15 2001	Barbara G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 04301

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Shirley W. Breitenother
2. Date of Death Month Day Year: February 12, 2001
3. Time of Death: 2:00 AM
4a. Facility Name *(If not institution, give street and number)*: Joseph Richey Hospice
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-18-0784
6. Sex: 1☐ M 2☑ F
7. Age *(In yrs. last birthday)*: 74 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 12, 1923
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 612 Brookwood Avenue
10f. Zip Code: 21229
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces?: 1☐ Yes 2☑ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Ricen, etc.): 1☐ Yes 2☑ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): — College (1-4or 5+): 1 year
16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Real Estate Management
16b. Kind of Business/Industry: Real Estate

17. Father's Name *(First, Middle, Last)*: Harry Lee Watts
18. Mother's Name *(First, Middle, Maiden Surname)*: Nellie May Fee

19a. Informant's Name/Relationship *(Type, Print)*: Shirley Breitenother/daughter
19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 1013 Rowe Lane Baltimore, Maryland 21228

20e. Method of Disposition: 1☑ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Western Cemetery
Date: 2/16/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: David J. Weber
22. Name and Address of Facility: David J. Weber Funeral Homes, P.A. 5311 Edmondson Avenue Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)
a. ASCVD — years

Due to (or as a consequence of):
b. Cerebrovascular accidents — 3 years

Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest
Due to (or as e consequence of):
c. Congestive heart failure — 1 year

Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: High blood pressure

23b. Did tobacco use contribute to the cause of death?: 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?: 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of ceuse of death?: 1☐ Yes 2☐ No

25. Was case referred to medical examiner?: 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Richey
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* hospice

27. Menner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury et Work?: 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner steted.

29b. Signeture end title of certifier: F. Powell M.D.
29c. License number: D 13006
29d. Date signed *(Month, Dey, Year)*: 2/12/01

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Thomas Powell, 101 W. Read St 21201

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 15 2001
32. Registrar's Signeture: James B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

2 Am 2/12/01 Shirley Breitenother

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04302

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Lou Cooke
2. Date of Death: Month February Dey 3, Yeer 2001
3. Time of Death: 3:11 P.M.
4a. Facility Name (If not institution, give street end number): 129 Bayside Drive
4b. City, Town, or Location of Death: Dundalk
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-32-1772
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Yaar: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): Jan 31, 1935
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 315 Wise Avenue
10f. Zip Code: 21222
10g. Citizen of What Country?: USA

11. Merital Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Evar In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 11yrs. | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): self employed
16b. Kind of Business/Industry: Beautitian

17. Father's Name (First, Middle, Last): Adam Kessler
18. Mother's Neme (First, Middle, Maiden Surneme): Mary Reneker

19a. Informant's Neme/Reletionship (Type, Print): Lisa Martin Daughter
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 8213 Shore Road Baltimore, Md 21222

20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Bayview Crematory
Date: 2/5/2001
20c. Location - City or Town, State: Baltimore City

21. Signature of Funaral Service Licensee: Anthony Connelly per DVR
22. Neme end Address of Fecility: Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road. Dundalk, Md 21222

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert feilure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Ceuse (Finel disease or condition resulting in death)
a. Renal Cancer — Due to (or es a consequence ot): — 5 months
b. Spinal metastasis — Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last
c. — Due fo (or es e consequence of):
d.

Pert II. **Other significant conditione** contributing to death but not rasulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yee 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Wara autopsy findings available prior to completion ot cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one)
Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) mother's home

27. Menner of Deeth: 1☐ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end plece, and due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the ceuse(s) and manner steted.

29b. Signeture end title of certifier: Charles Parker
29c. License number: D0051977
29d. Data signed (Month, Dey, Yeer): 2/5/01

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Charles Parker, FRANKLIN Square Hospital

State Registrar

31. Dete filed (Month, Day, Year): FEB 15 2001
32. Registrer's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 04303

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marcia Jean Carlen
2. Date of Death (Month, Day, Year): February 10 2001
3. Time of Death: 6:45 A.M.
4a. Facility Name (If not institution, give street and number): 313 Bigmount Ct.
4b. City, Town, or Location of Death: Abingdon
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 219-52-2899
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 52 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 12, 1948
9. Birthplace (State or Foreign Country): California

Usual Residence of Decedent

10a. State: Md
10b. County: Harford
10c. City, Town or Location: Abingdon
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 313 Bigmount Ct.
10f. Zip Code: 21009
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Registered Nurse
16b. Kind of Business/Industry: Montebello Hosp.

17. Father's Name (First, Middle, Last): Ignatius Ditchkus
18. Mother's Name (First, Middle, Maiden Surname): Virginia A. Arbaugh

19a. Informant's Name/Relationship (Type, Print): Frank R. Carlen
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 313 Bigmount Ct. Abingdon Md 21009

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bel Air Memorial Gdns. Date: Feb. 13 2001
20c. Location - City or Town, State: Bel Air, Md

21. Signature of Funeral/Service Licensee: Sheila L Wells
22. Name and Address of Facility: Evans Funeral Chapel 3 Newport Dr. Forest Hill, Md 21050

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Metastatic Carcinoma unknown primary
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marvin J. Feldman MD
29c. License number: D07930
29d. Date signed (Month, Day, Year): February 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Marvin Feldman 301 St. Paul Place Baltimore, Md 21202

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001
32. Registrar's Signature: Barbara B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04304

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Donald Chase

2. Date of Death: Month FEB. Dey 09 Year 2001

3. Time of Death: 10:55 am

4a. Facility Name (If not institution, give street and number): St AGNES HEALTHCARE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-30-9133

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 65 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 29, 1935

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 4351 Old Frederick Rd.

10f. Zip Code: 21229

10g. Citizen of What Country? USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+): 0

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): COOK

16b. Kind of Business/Industry: Restaurant

17. Father's Name (First, Middle, Last): unk.

18. Mother's Name (First, Middle, Maiden Surname): Sadie Chase

19a. Informant's Neme/Reletionship (Type, Print): (Cousin) Ms. Christine Chase

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 206 S. Tremont Rd. Balto. Md. 21229

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Othar (Specify)

20b. Place of Disposition (Nama of cemetery, crematory or other place): Mt. Zion | Date: 2/15/2001

20c. Location - City or Town, Stete: Lansdowne, Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ

22. Neme and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the daeth. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only ona causa on each line.

Approximata Intarval Between Onset end Deeth

Immediate Ceuse (Final disease or condition resulting in daeth)

e. BRAIN ANOXIA OF UNCLEAR ETIOLOGY — 5 DAYS

Due to (or es e consequence of):

b. SEVERE PULMONARY EDEMA — DAYS

Sequentially list conditions, if eny, laading to immediete ceusa. Entar Underlying Cause (Disease or injury that initieted events resulting in death) Last

Due to (or es e consequenca of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to daath but not resulting in the underlying cause given in Part I.

HIV INFECTION

HYPERTENSION

23b. Did tobacco uae contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yas 2 [X] No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1 [ ] Yas 2 [X] No

25. Wes case referred to medicel examiner? 1 [ ] Yas 2 [X] No

26. Place of Death (Check only ona): Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Homa 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be detarmined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner as statad. 2 [ ] **Medical Examiner:** On the besis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner steted.

29b. Signeture and title of certifier: [illegible], RESIDENT PHYSICIAN

29c. License number: P-14437

29d. Date signed (Month, Day, Year): FEB, 09, 2001

30. Neme end address of person who completed ceuse of death (Item 23a) (Type, Print): RACHEL ADDO-ASHONG 900 CATON AVE, BALTIMORE, MD 21229.

State Registrar

31. Dete filed (Month, Day, Year): FEB 15 2001

32. Registrar's Signature: [illegible] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospitalier Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

NAME DONALD CHASE

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04305

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LARRY WELDON CHRISTNER
2. Data of Death Month Day Year: FEBRUARY 13, 2001
3. Time of Death: 5:45 PM
4a. Facility Name *(If not institution, give street and number)*: 114 GARRETT ROAD
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 217-52-4633
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 51 Yrs. — If Under 1 Yaar: Months / Days — If Undar 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: MAY 31, 1949
9. Birthplace *(State or Foraign Country)*: MARYLAND

Usual Rasidance of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1 [ ] Yas 2 [X] No
10e. Street and Number: 114 GARRETT ROAD
10f. Zip Code: 21060
10g. Citizan of What Country?: U.S.A.

11. Maritat Status: 1 [ ] Navar Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1 [ ] Yas 2 [X] No If Yas, Giva Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No *Specify:*
14. Race - Amaricen Indian, Black, Whita, atc. *Specify:* WHITE

15. Decedent's Education *(Specify only highast grada completad)*: Elamantary/Secondary (0-12): 10 — Collega (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: BUTCHER
16b. Kind of Business/Industry: FOOD

17. Fathar's Nama *(First, Middla, Last)*: DARYLL CHRISTNER
18. Mothar's Nama *(First, Middle, Maiden Surnama)*: GERTRUE BOWMAN

19a. Informant's Name/Relationship *(Type, Print)*: MRS. GERTRUE CHRISTNER (MOTHER)
19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 114 GARRETT ROAD, GLEN BURNIE, MARYLAND 21060

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar *(Specify)*
20b. Place of Disposition *(Nama of cematary, cramatory or othar placa)*: LAKEMONT MEMORIAL PARK — Date: 02/17/2001
20c. Location - City or Town, Stata: DAVIDSONVILLE, MD.

21. Signatura of Funaral Service Licensee: R. George Hopkins
22. Nama and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part1. Entar tha disaase or complications that ceused tha daath. Do not antar tha moda of dying, such as cardiac or raspiretory arrest, shock, or heart tailura. List only one cause on each line. — Approximata Intarval Between Onset and Death

Immediata Ceusa (Final disaasa or condition rasulting in daath)
a. Coronary Artery Disease
Due to (or as a consequence of):
b. Acute Obstructive Lung Disease
Sequantially list conditions, if any, leeding to immadiata ceusa. Entar Underlying Cause (Diseasa or injury that initiated events rasulting tn death) Last
Dua to (or as a consequance of):
c. Hypertension
Due to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceusa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No
24b. Were autopsy findings available prior to completion of ceuse of deeth? 1 [ ] Yas 2 [X] No

25. Was cese referred to medical examinar? 1 [ ] Yas 2 [X] No
26. Plece of Deeth *(Check only one)*: Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Homa 5 [X] Residence 6 [ ] Othar *(Specify)*

27. Mennar of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding invastigation 6 [ ] Could not be datarmined
28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Dascribe how injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Cartifiar *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at tha tima, data and place, and dua to the ceuse(s) and menner as stated. 2 [ ] **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, death occurred at the tima, date and place, and dua to tha cause(s) and mannar steted.
29b. Signature and title of certifiar: Jorge M. Ramirez MD
29c. Licansa number: D36256
29d. Data signed *(Month, Day, Year)*: 2/14/01

30. Nama and addrass of person who completed ceusa of daath (Item 23a) (Type, Print): JORGE B. RAMIREZ, M.D., 7845 OAKWOOD ROAD, STE. 106, GLEN BURNIE, MD. 21061

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 15 2001
32. Registrar's Signatura: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04306

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Eileen R. Connolly
2. Date of Death (Month, Day, Year): February 12, 2001
3. Time of Death: 2:15 pm
4a. Facility Name *(If not institution, give street and number)*: Mariner Health Care of Laurel
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 032-09-3778
6. Sex: 1☐ M 2☒ F (X)
7. Age *(In yrs. last birthday)*: 80 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Mar 19, 1920
9. Birthplace *(State or Foreign Country)*: Mass.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☐ Yes 2☒ No (XX)
10e. Street and Number: 3531 Knollcrest Court
10f. Zip Code: 20724
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4(XX) Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes (XX) No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No (XX) *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*
Elementary/Secondary (0-12): Grade 12
College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Minister
16b. Kind of Business/Industry: Non-Denominational

17. Father's Name *(First, Middle, Last)*: Daniel Keefe
18. Mother's Name *(First, Middle, Maiden Sumeme)*: Mildred Markham

19a. Informant's Name/Relationship *(Type, Print)*: William Connolly / son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3531 Knollcrest Court Laurel, Maryland 20707

20a. Method of Disposition: 1☐ Burial 2(XX) Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory, Inc.
Date: Feb 13, 2001
20c. Location - City or Town, State: Catonsville, Maryland

21. Signature of Funeral Service Licensee: ▶ Gary S. Kyn / M00770
22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximete Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)
a. End stage Pancreatic cancer — 6 - 8 months
Due to (or as e consequence of):
b. Anemia
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Lest
c. Thrombocytopenia
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No (XX) 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No (XX)
24b. Were autopsy findings aveilable prior to completion of ceuse of deeth? 1☐ Yes 2☒ No (XX)

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No (XX)
26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☒ Nursing Home (XX) 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1(XX) Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end menner as steted. 2☐ **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, death occurred et the time, date and piece, end due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Kalman
29c. License number: D0053709
29d. Date signed *(Month, Day, Year)*: February 13, 2001

30. Name end address of person who completed ceuse of death (Item 23e) (Type, Print): Dr. Chowla 3060 Mitchellville Road Suite #103 Bowie, Maryland 20716

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 13 2001
32. Registrar's Signature: ▶ G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04307

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GERTRUDE CANTOR
2. Date of Death Month Dey Year: February 13 2001
3. Time of Death: 2:10 am
4a. Facility Name *(If not institution, give street and number)*: Sinai Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-03-5152
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 86 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: AUG. 19, 1914
9. Birthplace *(State or Foreign Country)*: PENNSYLVANIA

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3601 FORDS LANE #324
10f. Zip Code: 21215
10g. Citizen of Whet Country?: USA

11. Maritel Stetus: 1☒ Never Married 2☐ Merried 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - Americen Indien, Bleck, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SALES
16b. Kind of Business/Industry: RETAIL

17. Father's Neme *(First, Middle, Last)*: RABBI HARRY CANTOR
18. Mother's Name *(First, Middle, Maiden Surneme)*: DORA ADELMAN

19a. Informant's Neme/Reletionship *(Type, Print)*: GERALD LEFKOWITZ (NEPHEW)
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 3623 WASHINGTON AVE. BALTO., MD 21244

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Plece of Disposition *(Neme of cemetery, crematory or other piece)*: CONG. DEGEL ISRAEL — Date: 2/14/01
20c. Location - City or Town, Stete: LANCASTER, PA

21. Signature of Funerel Service Licensee: Robert Thomas
22. Name end Address of Fecility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line. — Approximete Intervel Between Onset end Death

Immediete Ceuse (Finel diseese or condition resulting in death)
a. Chronic Obstructive Polmonary disease
Due to (or es a consequence of):
b. Congestive heart failure
Sequentielly list conditions, if any, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in death) Lest
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. **Did tobacco use contribute to the cause of death?** 1☒ **Yes** 2☐ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveilable prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Wes cese referred to medicel exeminer? 1☐ Yes 2☒ No
26. Plece of Deeth *(Check only one)*: Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: Aidys Julia Valle M.D.
29c. License number: RES-000
29d. Date signed *(Month, Dey, Year)*: February 13, 2001

30. Neme and address of person who completed ceuse of deeth (Item 23e) (Type, Print): Sinai Hospital of Baltimore 2401 West Belvedere Baltimore Maryland

State Registrar

31. Dete filed *(Month, Day, Year)*: FEB 15 2001
32. Registrar's Signeture: Bonnie G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Cantore Gertrude

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 04308

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death (Month, Day, Year)	3. Time of Death
Jean	W.	Carter	February 13, 2001	7:15AM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
5608 Carter Avenue	Hamilton	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-30-0410	1☐M 2☒F	67 Yrs.			December 11, 1933	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	N/A	Hamilton	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5608 Carter Avenue	21214	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th Grade	N/A	Data Processor	Balto. City Police Dept

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Leonard Carter	Ruth Evelyn Gifford

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Hilda Hilpert/Friend	5608 Carter Avenue Baltimore MD 21214

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other piece)	Date	20c. Location - City or Town, Stete
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Jerusalem Lutheran	2/16/01	Baltimore, Maryland

21. Signature of Funeral Service Licensee: Christina D. Hetton

22. Name and Address of Facility: Leopard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Gastro intestinal bleeding	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnency 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date ot delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

Hypertension

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probebly 4☒Unknown

24a. Was en autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐Yes 2☒No

25. Was case referred to medicat examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as steted. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
John Schmitter MD	P 14137	February 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Schmitter MD Good Samaritan Hospital 5601 Loch Raven Blvd Baltimore MD 21239

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 15 2001	Benjamin G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #19A, 22 PER F.H. G792 2-15-01 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04309

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Data of Death Month	Day	Year	3. Time of Death
James	M.	Datcher	02	12	2001	3:00a.m.

4a Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Future Care Nursing Home	Baltimore	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-01-6411	XX 1☐M 2☐F	81 Yrs.					09 24 19	M.D.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Randallstown	1☐Yes XX No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3951 Nemo Road	21133	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married XX 3☐Widowed 4☐Divorced	1☒Yes 2☐No 9☐Yes, Give Year or Dates:	1☐Yes 2☒No Specify: X	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th grade	na	Shoe Repairman	Hutzler

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
James Datcher	Dora Griffin

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Denise D/Yancey-Daughter	3951 Nemo Road, Randallstown Md 21133

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Data	20c. Location - City or Town, State
1☒Burial 2☐Cramation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Garrison Forest Vet.	2/16/01	Owings Mills, Md

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
[signature]	~~Mar~~ F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. End Stage Renal Disease	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Hypertension	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☑Unknown	1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☑Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	D52794	2/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
COHN OTTEN MD 301 ST. PAUL PLACE SUITE 715 BALT. MD. 21202

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 15 2001	[signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04310

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Arlene DAVIS

2. Date of Death (Month, Day, Year): February 10 2001

3. Time of Death: 1635

4e. Facility Name (If not institution, give street and number): BON SECOUR HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-64-8382

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 46 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JUL 23 1954

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: ☒ Yes 2☐ No

10e. Street and Number: 1644 ASHBURTON STREET

10f. Zip Code: 21216

10g. Citizen of What Country? U.S.A.

11. Meritel Stetus: 1☐ Never Merried 2☐ Merried 3☐ Widowed 4☒ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes ☒ No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12): 12th grade

College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): NURSING ASSISTANT

16b. Kind of Business/Industry: BRIGHTON MANOR NURSING HOME

17. Fether's Neme (First, Middle, Last): CLARENCE BARBER

18. Mother's Neme (First, Middle, Maiden Surneme): BEATRICE GIBSON

19e. Informent's Neme/Reletionship (Type, Print): Stephanie Barber/Sister

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 4412 La Salle Ave., Baltimore, Maryland 21206

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Plece of Disposition (Neme of cemetery, cremetory or other plece): ARBUTUS MEMORIAL PARK

Dete: 2-16-01

20c. Location - City or Town, Stete: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Charles H. Powell

22. Name end Address of Feclity: WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one cause on eech line.

Approximete Interval Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in deeth)

a. METABOLIC ACIDOSIS — minutes

Due to (or as a consequence of):

b. PANCREATIC CANCER — months

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part tt. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contributs to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Deeth (Check only one)

Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)

☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted.

2☐ **Medical Examiner:** On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner steted.

29b. Signature end title of certifier: MD

29c. License number: 052113

29d. Date signed (Month, Day, Year): Feb 14 2001

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): R Paul Shumaker 301 St Paul Balto MD 21202

State Registrar

31. Dete filed (Month, Day, Year): FEB 15 2001

32. Registrer's Signeture: Barbara A Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04311

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph DiMartino
2. Date of Death (Month, Day, Year): February 13, 2001
3. Time of Death: 12:15am
4a. Facility Name (If not institution, give street end number): Frederick Villa Nursing Home
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-01-0143
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 83 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan., 19, 1918
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD.
10b. County:
10c. City, Town or Location: Baltimore
10d. Insida City Limits: 1 ☒ Yes 2 ☐ No
10e. Street end Number: 5009 Frederick Avenue
10f. Zip Code: 21229
10g. Citizen of Whet Country?: USA

11. Marital Status: 1 ☐ Never Merried 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Yeer or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puarto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Raca - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th — College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Commerical Printer
16b. Kind of Business/Industry: Paper

17. Fethar's Name (First, Middle, Last): Marion DiMartino
18. Mother's Name (First, Middle, Maiden Surneme): Augustine Cimino

19a. Informent's Name/Relationship (Type, Print): Lucy J. DiMartino - wife
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 5009 Frederick Avenue, Baltimore, MD., 21229

20a. Method of Disposition: 1 ☒ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Dulaney Valley Memorial — Date: 02-16-2001
20c. Location - City or Town, State: Timonium, MD.

21. Signature of Funaral Service Licensee: Bernard Dalinsky
22. Name and Address of Fecility: Witzke Funeral Home, Inc. 1630 Edmondson Ave. Catonsville, Maryland 21228

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. — Approximate Intervel Between Onset and Death

Immediate Ceuse (Final disaase or condition resulting in death): e. Atherosclerotic Cardiovascular Disease — minuts

Due to (or as e consequenca of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or es a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Pulmonary Fibrosis; Osteoarthritis

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Ware autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Piece of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner es stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the tima, date end piece, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Charles R Scalar Jr MD
29c. License number: D24781
29d. Date signed (Month, Dey, Year): February 13th, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 1001 PINE HGTS AVE - BALTO, MD 21229

State Registrar

31. Data filed (Month, Day, Year): FEB 15 2001
32. Registrar's Signature: Brenda D. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

01-0785-510
UNK 01-031
ASP

DONAHUE
WILLIAM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEM# 23,27& 28a-f G792 per [illegible] Certificate of Death

Reg. No. 2001 04312

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
William	Newman	Donahue	FEBRUARY 11 2001	01015 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
HARBOR HOSPITAL	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-88-6167	1☒M 2☐F	39 Yrs.			Nov. 20, 1961	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Glen Burnie	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
230 F Woodhill Drive	21061	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11 Years		Construction Worker	Construction

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumeme)
Thomas Donahue	Julie Sigmen

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
(Wife) Mrs. Deborah D. Donahue	230 F Woodhill Drive Glen Burnie, Maryland 21061

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Buriel 2☐Cremation 3☐Removel from State 4☐Donation 5☐Other (Specify)	Oak Lawn Cemetery	2/16/2001	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Grego E. Ro[illegible]	Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiec or respiratory errest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death): a. NARCOTIC INTOXICATION AND COCAINE USE

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b. Due to (or es a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE: 23b. Wes decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of deeth 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contnbuting to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contnbute to the cause of death? 1☐Yes 2☐No 3☐Probebly 4☐Unknown

24a. Was an autopsy performed? 1☑Yes 2☐No	24b. Were autopsy findings available prior to completion of cause of death? 1☑Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No	26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☒DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined	found: 2/11/01	found: 9:30 AM	1☐Yes 2☒No	unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
apartment	1317 E. Pontiac Ave., Balto., MD

29a. Certifier (Check only one) — 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steted. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
J Pestaner M.D.	O.C.M.E	FEBRUARY 12,2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrar's Signature
FEB 15 2001	[illegible] B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: Tha law requires that tha death certificate be executed within 72 hours after death.
To the Funeral Director: After this certificate has been signed by tha attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Junius Epps
mnmr
01-0590-510

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 04313

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Dey Yeer	3. Time of Death
Junius	Epps	February 03, 2001	1152 a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
University of Maryland Hospital	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Dey, Yeer)	9. Birthplece (State or Foreign Country)
213-30-4344	1 X M 2 ☐ F	65 Yrs.			Apr. 26, 1935	md.

Usuel Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
md	NA	Baltimore	1 X Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3908 Wabash Ave. Apt. 1B	21215	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ~~X~~ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ~~X~~ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grede completed)		16a. Decedent's Usual Occupetion (Give kind of work done during most of working life, DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8th	NA	Laundry	Laundry Co.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surneme)
UNKNOWN	UNKNOWN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
Dorothy Harper	3908 Wabash Ave Apt 1B Balto MD 21215

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other piece) Dete	20c. Location - City or Town, Stete
1 X Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify)	Voshell Memorial 2/12/2001	Balto, Md

21. Signature of Funeral Service Licensee: Wayne B Keke

22. Name and Address of Facility: ~~MARCH~~ Funeral Home West, Inc 4300 Wabash Ave. Balt. Md. 21215

Physician /Medical Examiner

23e. Pertl. Enter the diseese, or complications that ceused the deeth. Do not enter the mode of dying, such es cerdiec or respiratory errest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediete Cause (Final diseese or condition resulting in deeth)

a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as e consequence of):

Sequentlally list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

b. ____ Due to (or as a consequence of):

c. ____ Due to (or as a consequence of):

d. ____

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnency 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnancy 4 ☐ Pregnent at time of death 5 ☐ Other (specify) 9 ☐ Unknown	23d. Date of delivery Month Dey Year

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.

23e. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24e. Was en autopsy performed? 1 ☐ Yes 2 ☐ No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 X Yes 2 ☐ No	28. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☐ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury et Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated. 2 XX **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the ceuse(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Yeer)
Wayne B Keke MD	O.C.M.E.	February 04, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARYSANNE B. KOREN 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Yeer)	32. Registrar's Signature
FEB 15 2001	Geneva G. Sparks

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

ORIGINAL

2001 FEB 15 PM 3:31

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 04314

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Julianne Barbara Friedman
2. Date of Death (Month, Day, Year): February 13, 2001
3. Time of Death: 7:00 AM
4a. Facility Name (If not institution, give street and number): 4619 Keswick Road
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 074-05-6975
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC 2, 1915
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4619 Keswick Road
10f. Zip Code: 21210
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bookkeeper
16b. Kind of Business/Industry: Medical

17. Father's Name (First, Middle, Last): Karl Smoral
18. Mother's Name (First, Middle, Maiden Surname): Katherine Capp

19a. Informant's Name/Relationship (Type, Print): Robert J. Friedman/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4619 Keswick Road Baltimore, MD 21210

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc. | Date: 2-14-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Myeloproliferative Disorder
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Craig Gold DO
29c. License number: H 53088
29d. Date signed (Month, Day, Year): February 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Craig Gold DO 222 West Coldspring Lane Baltimore Maryland 21210

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001
32. Registrar's Signature: Jeanne D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04315

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES E. FERRELL
2. Dete of Deeth: Month 02 Dey 13 Yeer 2001
3. Time of Death: 5:45 A.M.
4e Facility Neme (If not institution, give street end number): 1081 Fitz Court
4b. City, Town, or Location of Deeth: Pasadena
4c. County of Deeth: Anne Arundel

Funeral Director

5. Social Security Number: 214-32-9582
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthdey): 65 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 30, 1935
9. Birthpiece (State or Foreign Country): Maryland

Usuet Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Pasadena
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 1081 Fitz Court
10f. Zip Coda: 21122
10g. Citizen of What Country?: U.S.A.
11. Maritel Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☒Yes 2☐No If Yes, Give Yeer or Dates: Vietnam
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No Specify:
14. Race - American Indien, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 — College (1-4or 5+): N/A
16a. Decedant's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired): Sgt. First Class
16b. Kind of Businass/Industry: U.S. Army
17. Fether's Neme (First, Middle, Last): James Wilson Ferrell
18. Mother's Neme (First, Middle, Maidan Surname): Catherine Wood
19e. Informent's Neme/Reletionship (Type, Print): Mary Ann Ferrell (Wife)
19b. Mailing Address (Street end Number or Rurel Route Numbar, City or Town, Stata, Zip Code): 1081 Fitz Court Pasadena, Maryland 21122
20e. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removel from State 4☐Donetion 5☐Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other pleca): Crownsville V.A. Cemetery
Date: 2/15/01
20c. Location - City or Town, State: Crownsville, Md.
21. Signeture of Funeral Service Licensee: John F. Collins
22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 3204 Mountain Rd. Pasadena, MD. 21122

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complications that caused the deeth. Do not enter the mode ot dying, such es cardiac or respiretory errest, shock, or heert feilure. List only ona causa on aach line.

		Approximeta Interval Batween Onset end Death
Immediate Cause (Finel disease or condition resulting in death) e.	LIVER CANCER	10 mths
Due to (or as a consequenca of):		
Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last — b.	CIRRHOSIS OF LIVER	5 yrs
Dua to (or es a consequenca ot):		
c.		
Due to (or es e consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributs to the causs of death? 1☐Yss 2☒No 3☐Probably 4☐Unknown

24a. Wes en eutopsy performed? 1☐Yes 2☒No

24b. Were eutopsy tindings eveilable prior to completion of cause of deeth? 1☐Yes 2☒No

25. Wes case referred to medical examiner? 1☐Yes 2☒No

26. Ptaca of Daath (Check only ona): Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☒Residenca 6☐Other (Specify)

27. Manner of Deeth: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicida 5☐Pending investigetion 6☐Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To tha best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and mannar as stated. 2☐**Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, data end pleca, end due to the ceuse(s) and menner steted.

29b. Signeture end title of certifier: Swati Desai, M.D.
29c. License number: D-43417
29d. Date signed (Month, Dey, Year): 2/13/01

30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print): SWATI M. DESAI, KIMBROUGH AMB. CARE CTR, FT. MEADE MD 20755

State Registrar

31. Dete filed (Month, Day, Year): FEB 15 2001
32. Registrer's Signeture: Renee G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-0711-510
cm
Isiah Graves

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM#1 per ME G795 052101 SS AMENDED ITEM 1,23a,ptII,27 per ME 051401 SS

Certificate of Death

Reg. No. 2001 04316

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Isaiah	Mazon	Graves	February 08, 2001	6:07 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Johns Hopkins Bayview Medical Center	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-59-2609	XX 1 M 2 F	Yrs.	2				11-20-2000	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	XX 1 Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5503 Hamlet Avenue	21214	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
XX 1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 XX No If Yes, Give Year or Detes:	1 Yes 2 XX No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
Infant	Infant	Infant	Infant

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Sumame)
Fred Graves	Cherquetta Maye

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 21218
George Mitchell	1900 N. Howard Street Baltimore, Maryland

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, State
XX 1 Burial 2 Cremation 3 Removel from Stete 4 Donation 5 Other (Specify)	King Mem. Pk. Cem.	02-15-2001	Randallstown, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. BRONCHIOLITIS IN ASSOCIATION WITH BRONCHOPULMONARY DYSPLASIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as e consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel deeth 3 Ectopic pregnency 4 Pregnant et time of deeth 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PREMATURITY

23e. Did tobecco use contribute to the cause of death?	24a. Was en autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?
1 Yes 2 No 3 Probebly 4 XX Unknown	XX 1 Yes 2 No	XX 1 Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
XX 1 Yes 2 No	Hospital: 1 Inpatient X 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
XX 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	
	28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one)
1 **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner es steted.
XX 2 **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
▶ [signature] M.D.	O.C.M.E.	February 09, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARY C. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 15 2001	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04317

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Louise Groce

2. Date of Death (Month, Day, Year): FEBRUARY 3, 2001

3. Time of Death: 04:30

4e. Facility Name (If not institution, give street and number): St. Agnes Health Care

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-36-1227

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 25, 1934

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 103 South Arlington

10f. Zip Code: 21223

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Waitress

16b. Kind of Business/Industry: Food Service

17. Father's Name (First, Middle, Last): Charles Belt

18. Mother's Name (First, Middle, Maiden Surname): Jessie Schriver

19e. Informant's Name/Relationship (Type, Print): John B. Groce / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 103 South Arlington, Baltimore, Maryland 21223

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery

Date: 2/6/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Bronchopneumonia — 2-3 days

Due to (or as a consequence of):
b. Arteriosclerotic cardiovascular disease — yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Hypertension — yrs

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Coagulopathy

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ William J Hicken MD

29c. License number: D0004964

29d. Date signed (Month, Day, Year): 2/3/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WILLIAM J HICKEN MD. ST AGNES HOSP. BALTIMORE, MD.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

MARY L. GROCE

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001

32. Registrar's Signature ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04318

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jay Herbert Gary

2. Date of Death (Month, Day, Year): February 10, 2001

3. Time of Death: 2:45 pm

4a. Facility Name (If not institution, give street and number): 9105 Dogwood Road

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-44-5838

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 55 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec 4, 1945

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 9105 Dogwood Road

10f. Zip Code: 21244

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Master Electrician

16b. Kind of Business/Industry: Self-Employed/Own Business

17. Father's Name (First, Middle, Last): Allen Gary

18. Mother's Name (First, Middle, Maiden Surname): Mary Gorman

19a. Informant's Name/Relationship (Type, Print): Beverly Ditch Gary / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 25, Woodstock, Maryland 21163

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory

Date: 2/15/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Juanita R Thomas

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrhythemia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Arteriosclerotic Cardio Renal Vascular Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [✓] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [✓] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Charles F. O'Donnell MD

29c. License number: D-09383

29d. Date signed (Month, Day, Year): February 10, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Charles F. O'Donnell MD 111 Hamlet Hill Rd Baltimore md 21210

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001

32. Registrar's Signature: Jennie G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

12+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 04319

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Dey Yeer	3. Time of Death
TENNIS MAE GLASS	FEBRUARY 13 2001	10:20P. M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
MANOR CARE	TOWSON	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Dete of Birth (Month, Dey, Year)	9. Birthplece (State or Foreign Country)
220-24-2114	1☐M 2☒F	79 Yrs.			MARCH 22 1921	VIRGINIA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	BALTIMORE	PARKVILLE	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8420 KINGS RIDGE ROAD A7	21234	U.S.A.

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Bleck, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Yeer or Detes:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8 YRS.		HOMEMAKER	AT HOME

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Surname)
WORLEY FRYE	TENNIS MAE HOUSHOUR

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
BETTY L. ADAMS	8420 KINGS RIDGE ROAD A7 PARKVILLE MARYLAND 21234

20a. Method of Disposition	20b. Piece of Disposition (Name of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	DULANEY VALLEY MEM.	FEB. 16, 2001	TIMONIUM, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶	EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD PARKVILLE MARYLAND 21234

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as e consequence of):

d. Due to (or as e consequence of):

IF FEMALE: 23b. Was decedent pregnent in the past 12 months? 1☐Yes 2☒No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant et time of deeth 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month Dey Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23e. Did tobecco use contribute to the ceuse of death? 1☐Yes 2☐No 3☐Probebly 4☒Unknown	
24e. Was en eutopsy performed? 1☐Yes 2☒No	24b. Were eutopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No	28. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1☐Yes 2☐No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)			28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) end menner es stated. 2☐**Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶	D52739	FEBRUARY 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SURESH SHANDILYA 300A Armory Place, Balt. Maryland

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 15 2001	▶

ORIGINAL

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04320

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Yvonne Gomez
2. Date of Death (Month, Day, Year): February 5, 2001
3. Time of Death: 9:00 PM
4a. Facility Name (If not institution, give street and number): Millenium Health Care Northwest
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 149-28-9793
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 25, 1920
9. Birthplace (State or Foreign Country): Oklahoma

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4601 Pall Mall Rd.
10f. Zip Code: 21215
10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 8
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Beautician
16b. Kind of Business/Industry: Self Employed

17. Father's Name (First, Middle, Last): unk
18. Mother's Name (First, Middle, Maiden Surname): unk

19a. Informant's Name/Relationship (Type, Print): Niece Mrs. Regina Glenn
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4872 123rd Place S.E. Bellevue, Washington 98006

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Crematory | Date: 2/12/2001
20c. Location - City or Town, State: Balto. Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Prostate Cancer
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
INSULIN DEPENDENT Diabetes Mellitus
MULTIPLE SECURITY

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2☑ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D24100
29d. Date signed (Month, Day, Year): 02-06-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M. L. PRASHAD M.D. 300 ARMORY PLACE SUITE 4A BALTIMORE MD 21202

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001
32. Registrar's Signature: Geneva B. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04321

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Julius C. Gawlik, Sr.
2. Date of Death (Month, Day, Year): February 11, 2001
3. Time of Death: 8:30 AM
4a. Facility Name (If not institution, give street and number): 4138 Beechwood Road
4b. City, Town, or Location of Death: Dundalk
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-34-0459
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 67 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 29, 1933
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4138 Beechwood Road
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1953-55
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years; College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Tavern Owner
16b. Kind of Business/Industry: Tavern

17. Father's Name (First, Middle, Last): Julius M. Gawlik
18. Mother's Name (First, Middle, Maiden Surname): Loretta Bocklage

19a. Informant's Name/Relationship (Type, Print): (Wife) Mrs. Patricia A. Gawlik
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4138 Beechwood Road Dundalk, Maryland 21222

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Entombment
Date:
20c. Location - City or Town, State: Gardens of Faith Cem. 2/15/2001 Baltimore, Maryland

21. Signature of Funeral Service Licensee: Gregg E. Ruck
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Heart failure
Due to (or as a consequence of):
b. Cancer of esophagus
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R. Sajadi MD
29c. License number: D0018951
29d. Date signed (Month, Day, Year): 2-13-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Reza Sajadi, M.D. 1005 North Pt. Blvd. Suite 706 Baltimore, Maryland 21224

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04322

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret Teresa Helt

2. Date of Death: Month February Day 12 Year 2001

3. Time of Death: 7:40 am

4e. Facility Name (If not institution, give street and number): 107 Melvin Avenue

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-22-9022

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10/7/1915

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 107 Melvin Avenue

10f. Zip Code: 21228

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Social Worker

16b. Kind of Business/Industry: Social Work

17. Father's Name (First, Middle, Last): George Lawrence Brittinghan

18. Mother's Name (First, Middle, Maiden Surname): Irene Nolen

19a. Informant's Name/Relationship (Type, Print): Tom Helt - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 105 Melvin Avenue, Catonsville, Maryland 21228

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Olive United Methodist | Date: 2/14/01

20c. Location - City or Town, State: Randallstown, Maryland

21. Signature of Funeral Service Licensee: Michele N Vetula

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. metastatic esophageal carcinoma — One year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CVA (cerebrovascular accident)

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Damian E Birchess MD

29c. License number: 022114

29d. Date signed (Month, Day, Year): 2/13/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Damian Birchess MD. 5411 Old Frederick Road, Baltimore, Maryland 21229

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001

32. Registrar's Signature: Denise G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04323

SARAH HORNBERGER

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last): SARAH LEONA HORNBERGER
2. Date of Death (Month, Day, Year): February 12 2001
3. Time of Death: 8:00 A.m.
4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL ASSOCIATION
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL
5. Social Security Number: 212-46-6155
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 54 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG. 13, 1946
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: SEVERN
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7854 SPRUCE HILL ROAD
10f. Zip Code: 21144
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): EXECUTIVE SECRETARY
16b. Kind of Business/Industry: TECHNOLOGY
17. Father's Name (First, Middle, Last): FRANCIS SHEFFIELD
18. Mother's Name (First, Middle, Maiden Surname): HAZEL BOOKER
19a. Informant's Name/Relationship (Type, Print): MR. DALE HORNBERGER, SR. (HUSBAND)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7854 SPRUCE HILL ROAD, SEVERN, MARYLAND 21144
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CHESAPEAKE CREMATION CENTER, LLC. STEVENSVILLE, MD.
Date: 2/13/2001
20c. Location - City or Town, State
21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. LUNG CANCER
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MA
29c. License number: D43977
29d. Date signed (Month, Day, Year): February 12 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Angela Oberling, 301 Hospital Drive, Glen Burnie MD 21061

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04324

Hill, Loretta 2-6-01 836 pm

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner — **Funeral Director** — **To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): LORETTA ALICE HILL					2. Date of Death (Month, Day, Year): FEBRUARY 6, 2001			3. Time of Death: 8:36pm
4a. Facility Name (If not institution, give street and number): THE GILCHRIST CENTER				4b. City, Town, or Location of Death: BALTIMORE		4c. County of Death		
5. Social Security Number: 219-38-7887	6. Sex: 1☐ M 2☑ F	7. Age (In yrs. last birthday): 59 Yrs.	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year): DEC. 22, 1941			9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND		BALTIMORE	1☑ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1216 GLENHAVEN ROAD	21239	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☑ No If Yes, Give Year or Dates:	1☐ Yes 2☑ No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		DAYCARE PROVIDER	PRIVATE

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
VERNON GOUGH	ELEANOR YOUNG

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
CHARLES HILL / HUSBAND	1216 GLENHAVEN ROAD

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	MARYLAND NATIONAL	2-10-01	LAUREL, MARYLAND

21. Signature of Funeral Service Licensee		22. Name and Address of Facility
▶	MD1015	VAUGHN C. GREENE FUNERAL HOME 5151 BALTIMORE NAT'L PIKE BALTIMORE, MD 21229

Physician /Medical Examiner — **Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Colorectal ca	years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ovarian ca, CVA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D0051926	Feb 7, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Helen M Gordon MD 6565 N. Charles St, Baltimore MD 21204

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 15 2001	▶

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04325

Jeddock, Rosalie

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last): Rosalie Emma Jeddock		2. Date of Death: Month February Day 10 Year 2001	3. Time of Death: 6:20pm
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center	4b. City, Town, or Location of Death: Rosedale	4c. County of Death: Baltimore	
5. Social Security Number: 213-36-9312	6. Sex: 1☐ M 2☒ F	7. Age (In yrs. last birthday): 61 Yrs.	If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 9, 1939	9. Birthplace (State or Foreign Country): Washington DC		

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Baltimore	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizan of What Country?
7853 Kavanagh Road	21222	USA

11. Marital Stetus	12. Wes Decedent Evar in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Raca - Amarican Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Detes:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
8		Homemaker	Own Home

17. Fether's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumama)
William Cloman	Alice Hitchcock

19a. Informent's Name/Reletionship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Sandra Dargakis/Daughter	3328 Joann Lane Fallston, MD 21047

20e. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, Stete
1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)	Metro Crematory Inc.	2-15-01	Baltimore, MD

21. Signature of Funeral Service Licensee	22. Name end Address of Facility
Thomas Gregor	Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

		Approximete Interval Between Onset end Death
Immediate Causa (Finel disaase or condition resulting in death)	e. Adult Respiratory Distress Syndrome	3 Days
Due to (or es e consequence of):		
Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in daeth) Last	b. Pneumonia	5 Days
Dua to (or as a consequanca of):		
	c. Myocardial Infarction	5 Days
Due to (or es e consequence of):		
	d. Anemia	3 Months

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en autopsy performed?	24b. Were autopsy findings eveileble prior to completion of cause of deeth?
1☒ Yes 2☐ No	1☐ Yes 2☒ No

25. Wes case referred to medical examiner?	26. Plece of Deeth (Check only one)	
1☐ Yes 2☒ No	Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Mennar of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)			28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of examinetion and/or invastigetion, in my opinion, daath occurred at the tima, data and placa, and dua to tha causa(s) end manner steted.

29b. Signeture end Title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Ronald Jeffreys M.D.	H00052365	February 14, 2001

30. Neme end address of person who completed causa of death (Item 23a) (Type, Print): Dr Ronald Jeffreys 9000 Franklin Square Drive Baltimore, MD 21237

State Registrar

31. Deteffiled (Month, Day, Year)	32. Registrer's Signature
FEB 15 2001	Penny D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04326

Kraska, Lillian

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last): Lillian L. Kraska			2. Date of Death: Month: February Day: 14 Year: 2001			3. Time of Death: 1053 AM
4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore			4b. City, Town, or Location of Death: Baltimore			4c. County of Death: N/a
5. Social Security Number: 215-52-1933	6. Sex: 1☐ M 2☒ F	7. Age (In yrs. last birthday): 92 Yrs.	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year): Feb 9, 1909	9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Baltimore	Dundalk	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1932 Snyder Ave	21222	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8 yrs.		Housewife	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Lewis Courtney	Lucy Abel

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Nancy Belsinger Daughter	1932 Snyder Ave, Dundalk, Md. 21222

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Christ Lutheran Cemetery	Feb. 16 2001	Dundalk, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Anthony C. Connelly	Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, Md. 21222

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Atrial Fibrillation

Due to (or as a consequence of):
c. Dehydration

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Alzheimer's

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] DO	RES000	February 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
John A. Matteo, III DO 2401 Belvedere Ave Baltimore MD 21215

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 15 2001	[signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04327

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Krishna Koindala

2. Dete of Death (Month, Dey, Year): 02/13/2001

3. Time of Death: 3:45 AM

4a Facility Neme (If not institution, giva street end number): Laurel Regional Hospital

4b. City, Town, or Location of Deeth: Laurel

4c. County of Deeth: Prince Georges

Funeral Director

5. Social Security Number: Unknown

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthdey): 68 Yrs.

If Under 1 Yeer: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): 01/16/1933

9. Birthplace (Stata or Foreign Country): India

Usuel Residence of Decedent

10a. Stete: MD

10b. County: Prince Georges

10c. City, Town or Location: Beltsville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 11922 Twin Lakes Drive

10f. Zip Code: 20705

10g. Citizan of What Country?: India

11. Meritel Stetus: 1 [ ] Never Merried 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Evar in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yas, Give Yaer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Maxican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Black, Whita, etc. Specify: Asian/Indian

15. Decedent's Eduction (Specify only highest greda completed): Elementery/Secondary (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Doctor

16b. Kind of Business/Industry: Medical

17. Father's Neme (First, Middla, Last): Chinnaswamy Koindala

18. Mothar's Name (First, Middle, Meiden Sumame): Jeevammak Khoinoor

19a. Informant's Name/Ralationship (Type, Print): Dhanalaxmi Koindala-wife

19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Coda): 11922 Twin Lakes Drive, Beltsville, MD., 20705

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremetion 3 [ ] Ramoval from Stata 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetary, cramatory or other placa): Balt./Wash. Crematory

Date: 02/15/01

20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: Norie McCann

22. Nema and Address of Facility: Fleck Funeral Home, 7601 Sandy Springs Road, Laurel, MD., 20707

Physician /Medical Examiner

23a. Part I. Enter tha disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one causa on eech line.

Approximeta Intervel Between Onset end Deeth

Immediate Ceuse (Finel disaese or condition resulting in deeth)

a. Cardiovascular Accident

Due to (or es e consequenca of):

Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Diseese or Injury that initieted events rasulting in death) Last

b. Respiratory Failure

Due to (or as a consequence of):

c.

Dua to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uea contribute to the cauee of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Wara autopsy findings eveileble prior to completion of cause of death? 1 [ ] Yas 2 [X] No

25. Wes case referred to medicel exeminer? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residanca 6 [ ] Other (Specify)

27. Mannar of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be datarmined

28a. Data of Injury (Month, Dey Yeer)

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Dascribe how injury occurred

28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] **Certifying Phyeician**: To tha best of my knowledge, daeth occurred et tha tima, dete end plece, and dua to the ceuse(s) end menner as stated. 2 [ ] **Medical Examiner:** On the basis of exeminetion end/or investigation, in my opinion, death occurred et tha time, data end placa, end dua to the cause(s) end mannar statad.

29b. Signeture and title of certifier: Kasin

29c. License number: D0053709

29d. Date signed (Month, Dey, Year): 2/13/01

30. Name end address of person who complated cause of daath (Item 23a) (Type, Print): KASIN 7300 VANDUESEN ROAD, LAUREL, MD. 20707

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001

32. Registrar's Signature: Steven G. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04328

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bertha Kendrynka

2. Date of Death: Month 2 Day 10 Year 01

3. Time of Death: 3:45 Am.

4a. Facility Name (If not institution, give street and number): Cadesis Multi Medical Center

4b. City, Town, or Location of Death: Towson, Md.

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-05-9781

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 8/27/11

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Parkton

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 18 Stablers Court

10f. Zip Code: 21120

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Joseph Dombrowski

18. Mother's Name (First, Middle, Maiden Surname): Veronica Gutowski

19a. Informant's Name/Relationship (Type, Print): Dorothy Whiteford / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 717 Parkton, Maryland 21120

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Redeemer Cemetery

Date: 02/14/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: David J. Weber

22. Name and Address of Facility: David J. Weber Funeral Homes, P.A. 401 S. Chester Street Baltimore, Maryland 21231

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death) e. Failure to Thrive — Months

Due to (or as a consequence of): Senile Dementia — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cauee of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D17118

29d. Date signed (Month, Day, Year): Feb 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Schwartz MD 7700 York Rd 21204

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEMS #10e & 19b per fh G792 021501 SS

Certificate of Death

Reg. No. 2001 04329

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ZENA K. KLEIN

2. Date of Death: Month FEB Day 11 Year 2001

3. Time of Death: 1127 AM

4e. Facility Name (If not institution, give street and number): HOWARD COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death: COLUMBIA

4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 231-36-9009

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Yaar: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JAN.9,1931

9. Birthplace (State or Foreign Country): D.C.

Usual Residence of Decedent

10a. State: MD

10b. County: HOWARD

10c. City, Town or Location: ELLICOTT CITY

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 7627 ~~7727~~ STONEY CREEK LANE

10f. Zip Code: 21043

10g. Citizen of Whet Country?: U.S.A.

11. Merital Status: 1☐ Naver Merriad 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Raca - American Indien, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ADMINISTRATOR

16b. Kind of Business/Industry: NATIONAL SECURITY AGENCY

17. Father's Name (First, Middle, Last): ISADORE KOBERNICK

18. Mother's Name (First, Middle, Maiden Surname): ROSE MARKOWITZ

19a. Informant's Name/Relationship (Type, Print): JACK KLEIN / HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7627 ~~7727~~ STONEY CREEK LANE - ELLICOTT CITY, MD 21043

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Pleca of Disposition (Name of cemetery, crematory or other piece): MD VETERANS CEMETERY

Date: 2/14/01

20c. Location - City or Town, State: CHELTENHAM, MD

21. Signature of Funeral Service Licensee: Robert S. Levinson

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximete Interval Between Onset end Death

Immediete Cause (Finel disease or condition resulting in deeth): e. metastatic colon cancer to liver

Dua to (or as a consequence of): b. colon cancer. 4yars

Sequentially list conditions, if eny, leeding to immadiate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in deeth) Lest

Dua to (or es a consaquenca of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uee contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Plece of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Deta of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner steted.

29b. Signeture end title of certifier: Michael S. Klein MD.

29c. License number: D30763

29d. Date signad (Month, Day, Year): FEB 11, 2001

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print): 4801 Woods Hill Dr, Suite 222, Ellicott City, MD 21042

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001

32. Registrer's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health end Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after deeth.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04330

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sandra Mary Kunaniec
2. Date of Death (Month, Day, Year): February 13, 2001
3. Time of Death: 7:10 AM
4e. Facility Name (If not institution, give street and number): Stella Maris Hospice
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-66-3276
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 47 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): October 11, 1953
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Fallston
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2905 Nelson Lane
10f. Zip Code: 21047
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+): 5+
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Neurophysiology Technician
16b. Kind of Business/Industry: Medical

17. Fether's Name (First, Middle, Last): Alexander P. Kunaniec, Sr.
18. Mother's Neme (First, Middle, Maiden Surneme): Marie B. Faber

19a. Informant's Neme/Reletionship (Type, Print): Barbara Berting/Sister
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 2905 Nelson Lane Fallston Maryland 21047

20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Gardens of Faith
Dete: 2/16/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Christina L. Hilton — Christina L. Hilton
22. Neme end Address of Fecility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Cause (Finel diseese or condition resulting in death): e. OVARIAN CANCER

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Lest

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) HOSPICE

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) and manner es steted.
2☐ **Medical Examiner:** On the besis of exemination and/or investigation, in my opinion, deeth occurred at the time, dete end placa, end due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier: [illegible]
29c. License number: D43725
29d. Date signed (Month, Day, Year): 2/13/01

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

31. Dete filed (Month, Dey, Yeer): FEB 15 2001
32. Registrer's Signeture: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

FEBUARY 13, 2001 7:10 a.m.

Baltimore, Maryland 21215-0036

SANDRA KUNANIEC

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04331

Helen Lyall #02-84-88

Physician /Medical Examiner

1. Decedent's Nama *(First, Middla, Last)*: HELEN JANE LYALL
2. Date of Death (Month, Day, Year): FEBRUARY 11, 2001
3. Tima of Death: 4:25 PM
4a. Facility Nama *(If not institution, give street and number)*: Saint Joseph Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 242-36-7600
6. Sax: 1☐ M 2☒ F
7. Aga *(In yrs. last birthday)*: 71 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: JULY 10, 1929
9. Birthplace *(Stata or Foraign Country)*: NORTH CAROLINA

Usual Residence of Decadant

10a. Stata: MARYLAND
10b. County: BALTIMORE
10c. City, Town or Location: WHITE MARSH
10d. Insida City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 11701 HAMILTON PLACE
10f. Zip Coda: 21162
10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decadant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Give Yaar or Datas:
13. Was Decadant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decadant's Education *(Specify only highast grada completed)*: Elamentary/Secondary (0-12): 12 YRS. / Collega (1-4or 5+):
16a. Decadant's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT use retired)*: EMPLOYEE
16b. Kind of Businass/Industry: WESTINGHOUSE CO.

17. Father's Nama *(First, Middla, Last)*: PAUL GRADY HUSKINS
18. Mothar's Nama *(First, Middle, Maiden Surname)*: ZONA PEARL LEOBETTER

19a. Informant's Name/Ralationship *(Type, Print)*: MICHAEL K. LYALL
19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 901 WEST RING FACTORY ROAD JOPPA MARYLAND 21085

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other *(Specify)*
20b. Placa of Disposition *(Nama of camatary, cramatory or othar placa)*: HIGHVIEW MEMORIAL — Data: FEB. 16, 2001
20c. Location - City or Town, Stata: FALLSTON, MARYLAND

21. Signatura of Funeral Service Licensee: [signature]
22. Nama and Address of Facility: EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE MARYLAND 21234

Physician /Medical Examiner

23a. Part1. Enter the disaasa, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or haart failura. List only one cause on aach lina.

Approximata Interval Batween Onset and Daath

Immediate Cause (Finel disaasa or condition rasulting in deeth): a. MASSIVE PULMONARY EMBOLUS — 3 HOURS

Dua to (or as a consequenca of):

Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Ceuse (Diseese or injury that initiated events rasulting in deeth) Last:
b.
Dua to (or as a consequenca of):
c.
Due to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco uae contribute to the cauae of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to compiation of cause of daath? 1☐ Yas 2☐ No

25. Wes casa rafarred to medical axaminar? 1☐ Yas 2☒ No

26. Pleca of Death *(Check only one)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Streat and Number or Rurel Routa Number, City or Town, Stata)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledge, daeth occurred et tha tima, deta and placa, and dua to tha causa(s) and mannar es steted. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigetion, in my opinion, daeth occurred et the time, date end pleca, and due to the ceuse(s) and mannar stated.

29b. Signature and title of certifier: H. Neal Reynolds
29c. Licansa number: D27163
29d. Date signed *(Month, Day, Year)*: 2/12/2001

30. Name and address of person who complated causa of daath (Item 23a) (Type, Print): HOWARD NEAL REYNOLDS M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204

State Registrar

31. Data filed *(Month, Day, Year)*: FEB 15 2001
32. Registrar's Signature: [signature]

ORIGINAL

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04332

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Verna May Luthardt
2. Date of Death Month Day Year: Feb. 9, 2001
3. Time of Death: 8:58PM
4a Facility Neme *(If not institution, give street end number)*: 308 First Ave.
4b. City, Town, or Location of Death: Lansdowne
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-12-3185
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. lest birthdey)*: 77 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Day, Year)*: Oct. 14, 1923
9. Birthplace *(Stete or Foreign Country)*: MD

Usuel Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Lansdowne
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 308 First Ave.
10f. Zip Code: 21227
10g. Citizen of Whet Country?: U.S.A.
11. Merital Stetus: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Detes: 1943-1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondary (0-12): 10 / College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home
17. Fether's Neme *(First, Middle, Last)*: Benjamin Young
18. Mother's Name *(First, Middle, Maiden Sumame)*: Grace Daulton
19a. Informent's Neme/Relationship *(Type, Print)*: Fred Luthardt, Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 308 First Ave. Lansdowne, MD. 21227
20e. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Loudon Park Cemetery
Dete: 2-10-01
20c. Location - City or Town, State: Baltimore, MD
21. Signature of Funeral Service Licensee: Rebecca Robinson
22. Name end Address of Fecility: Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne, MD. 21227

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Interval Between Onset and Death

Immediete Ceuse (Finel diseese or condition resulting in deeth)
a. Cardiac Arrest — instant

Due to (or es a consequence of):
b. ASCVD — years

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in death) Last
Due to (or es a consequence of):
c. Diabetes Mellitus — years

Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*
27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred at the fime, date end place, end due to the ceuse(s) end manner steted.
29b. Signature and title of certifier: MD
29c. License number: D-12550
29d. Dete signed *(Month, Day, Year)*: 2/11/01
30. Name end address of person who completed cause of death (Item 23e) (Type, Print): JAMES QUINLAN, MD 7801 YORK RD #101 TOWSON, MD 21204

State Registrar

31. Dete filed *(Month, Dey, Year)*: FEB 15 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 04333

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Donohue S. Lankford
2. Date of Death (Month, Day, Year): Feb. 10 2001
3. Time of Death: 3:30 PM
4a. Facility Name (If not institution, give street and number): 9608 Oak Summit Ave.
4b. City, Town, or Location of Death: Parkville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-18-6773
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct 30 1923
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 9608 Oak Summit Ave.
10f. Zip Code: 21234
10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+): —
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): medical policy
16b. Kind of Business/Industry: Blue Cross & Blue Shield

17. Father's Name (First, Middle, Last): Paul Sheets
18. Mother's Name (First, Middle, Maiden Surname): Vera Viers

19a. Informant's Name/Relationship (Type, Print): Bradley Lankford
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 706 MacPhail Ct. North Bel Air Md 21014

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith
Date: Feb. 14 2001
20c. Location - City or Town, State: Rosedale Md.

21. Signature of Funeral Service Licensee: Leota L Wells
22. Name and Address of Facility: Evans Funeral Chapel 8800 Harford Rd. Baltimore, Md 21234

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Retroperitoneal Sarcoma — 2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month / Day / Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Robert Stoner MD
29c. License number: D13272
29d. Date signed (Month, Day, Year): 2-12-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Robert Stoner 7505 Oslee Dr. Towson, Md.

Medical Certification; To Be Completed by Physician/Medical Examiner

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001
32. Registrar's Signature: Donna D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04334

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ruth Laverne Leppert

2. Data of Death Month Day Year: 2/10/2001

3. Tima of Death: 4:40 AM

4a Facility Nama *(If not institution, give street and number)*: 6 Belinda Avenue

4b. City, Town, or Location of Death: Baltimore Co.

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216 03 0367

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 81 Yrs. | If Undar 1 Yaar: Months / Days | If Undar 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: December 12 1919

9. Birthplaca *(State or Foreign Country)*: Baltimore City, Md.

Usual Residence of Decedent

10a. Stata: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore County

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street end Number: 6 Belinda Avenue

10f. Zip Coda: 21206

10g. Citizen of What Country?: USA

11. Marital Stetus: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Amarican Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | Collega (1-4or 5+): NA

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: Housekeeping-Own Home

17. Father's Nama *(First, Middle, Last)*: Frank Mulligan

18. Mothar's Nama *(First, Middle, Maiden Sumame)*: Eleanor Schultz

19a. Informant's Name/Relationship *(Type, Print)*: Gerry Olkowski

19b. Mailing Addrass *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6 Belinda Avenue Baltimore, Maryland 21206

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other placa)*: Most Holy Redeemer Cem. | Data: February 13 2001

20c. Location - City or Town, Stata: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Heather Lassahn Chapnick

22. Name and Addrass of Facility: Lassahn Funeral Home Inc. 7401 Belair Road Baltimore, Maryland 21236

Physician /Medical Examiner

23a. Part1. Enter the disease or complications that caused tha death. Do not antar tha moda of dying, such as cardiac or raspiratory errast, shock, or heart failure. List only one cause on each line.

		Approximate Interval Batween Onsat and Death
Immediata Causa (Final diseasa or condition resulting in death) a.	Pulmonary Edema	1 day
Dua to (or as a consequenca of): b.	Congestive Heart failure	10 yrs
Sequentially list conditions, if any, leading to immadiata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Dua to (or as a consequance of): c.	Renal Failure	1 yr
Dua to (or as a consequance of): d.	Hypertension	20 yrs

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Wara autopsy findings availabla prior to compiation of cause of daath? 1☐ Yas 2☐ No

25. Was case refarred to medical examiner? 1☐ Yas 2☒ No

26. Placa of Daath *(Check only one)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA | Othar: 4☐ Nursing Homa 5☒ Rasidance 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yas 2☐ No | 28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and manner as statad. 2☐ **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and mannar stated.

29b. Signeture and title of certifiar: ▶ Kristin M Clark, MD

29c. License number: 053966

29d. Data signad *(Month, Day, Year)*: 02-12-01

30. Nama end address of person who complated causa of daath (Item 23a) (Type, Print): Kristin M Clark, MD 9101 Franklin Square Drive Suite 205 Baltimore, MD 21237

State Registrar

31. Data filed *(Month, Day, Year)*: FEB 15 2001

32. Registrar's Signature: ▶ D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 04335

LACAZE, ROBERT February 6, 2001 10:15 a.m.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

As the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert D. Lacaze Sr.
2. Date of Death (Month, Dey, Yeer): 2/6/2001
3. Time of Death: 10:15 AM
4a. Facility Neme (If not institution, give street end number): Gilchrist Center Hospice
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 074-14-2370
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 78 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): 7/10/1922
9. Birthplece (State or Foreign Country): New York, NY

Usuel Residence of Decedent

10a. Stete: MD
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 6 Airway Circle Apt. 3C
10f. Zip Code: 21286
10g. Citizen of Whet Country?: USA

11. Meritel Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Detes: WWII/Korea
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 years; College (1-4or 5+): N/A
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): General Sales Manager
16b. Kind of Business/Industry: Peerless Imports, Inc.

17. Father's Neme (First, Middle, Last): August Lacaze
18. Mother's Name (First, Middle, Maiden Sumame): Helen Farrell

19a. Informent's Neme/Reletionship (Type, Print): Mary Lacaze (wife)
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 6 Airway Circle Apt 3C Towson, MD 21286

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Piece of Disposition (Neme of cemetery, crematory or other pleca): Arlington National Cemetery
Dete: 2/15/2001
20c. Location - City or Town, Stete: Arlington, VA

21. Signature of Funeral Service Licensee: E.F. Lassahn
22. Neme end Address of Fecility: E.F.Lassahn Funeral Home 11750 Belair Rd. Kingsville, MD 21087

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximate Interval Between Onset end Deeth

Immediete Cause (Finel diseese or condition resulting in deeth): e. prostate cancer — years
Due to (or es a consequenca of):

Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Last:
b. Due to (or as e consequenca of):
c. Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Piece of Deeth (Check only one): Hospitel: 1 [ ] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice

27. Menner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined
28a. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2 [ ] **Medicel Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: Anthony Riley
29c. License number: D25205
29d. Date signed (Month, Dey, Yeer): February 6, 2001

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Balto. md 21204

State Registrar

31. Dete filed (Month, Day, Year): FEB 15 2001
32. Registrer's Signeture: Donna D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04336

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Albert Lemmer

2. Date of Death (Month, Day, Year): February 10, 2001

3. Time of Death: 9:50 PM

4a. Facility Name (If not institution, give street and number): Cromwell Center Genesis Eldercare

4b. City, Town, or Location of Death: Parkville

4c. County of Death: Baltimore Co.

Funeral Director

5. Social Security Number: 112-09-7588

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 24, 1915

9. Birthplace (State or Foreign Country): Oklahoma

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8217 Longpoint Road

10f. Zip Code: 21222

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Pipefitter

16b. Kind of Business/Industry: Shipyard

17. Father's Name (First, Middle, Last): Nicholas Lemmer

18. Mother's Name (First, Middle, Maiden Surname): Catherine Behl

19a. Informant's Name/Relationship (Type, Print): Robert G. Lemmer (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 849 Streaker Road Sykesville, Maryland 21784

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith Cem. Date: 2/13/2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure — year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Acute Renal Insufficiency, Chronic Kidney Failure, Dementia, Carotid Bypass, PVD

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Martha C. Raymundo MD

29c. License number: D54518

29d. Date signed (Month, Day, Year): 2/12/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Martha C. Raymundo 3007 E Northern Parkway Baltimore MD 21214

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

VOID

CERTIFICATE #

01-04337

SEE

CERTIFICATE #

00-436428

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04338

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Herbert Morsberger

2. Date of Death: Month FEB, Day 14, Year 2001

3. Time of Death: 1:23pm

4e. Facility Name (If not institution, give street and number): 7412 Old Washington Road

4b. City, Town, or Location of Death: Woodbine

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 217-26-8626

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Dey, Yeer): JUNE 25, 1930

9. Birthplece (State or Foreign Country): Maryland

Usuel Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Woodbine

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street end Number: 7412 Old Washington Road

10f. Zip Code: 21797

10g. Citizen of Whet Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever In U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: 1950-1954

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] Yes [X] No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Eduction (Specify only highest grede completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Salesman

16b. Kind of Business/Industry: Meat Industry

17. Father's Name (First, Middle, Last): Howard William Morsberger

18. Mother's Name (First, Middle, Maiden Sumeme): Sarah Latimier Hoyer

19a. Informant's Name/Reletionship (Type, Print): Phyllis S. Morsberger/Wife

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 7412 Old Washington Road Woodbine, MD 21797

20e. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other place): Metro Crematory Inc.

Date: 2-15-01

20c. Location - City or Town, Stete: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik

22. Name end Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet ceused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediate Ceuse (Final disease or condition resulting in death): e. METASTATIC LUNG CA — 6 mos

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest:

b. Due to (or es e consequence of):

c. Due to (or as e consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cauee of deeth? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings evellable prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Piece of Deeth (Check only one): Hospital: 1 [ ] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28e. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1 [X] **Certifying Phyeician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner as steted. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated.

29b. Signeture end title of certifier: Flavio Kruter MD

29c. License number: D38398

29d. Date signed (Month, Dey, Year): 2-15-01

30. Name end eddress of person who completed ceuse of death (Item 23e) (Type, Print): Flavio Kruter, M.D. 555 S. Center Street Westminster, MD 21157

State Registrar

31. Date filed (Month, Dey, Year): FEB 15 2001

32. Registrer's Signeture: Sandra D. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 04339

Mock, Bertha

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bertha Mock

2. Date of Death Month Dey Yeer: February 13,2001

3. Time of Death: 12:45 PM

4a. Facility Name (If not institution, give street and number): Greater Baltimore Medical Center

4b. City, Town, or Location of Deeth: Towson

4c. County of Deeth: Baltimore

Funeral Director

5. Social Security Number: 216-20-9388

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): 03-15-16

9. Birthplece (State or Foreign Country): DC

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 3800 W. Belvedere Avenue Apt. #322

10f. Zip Code: 21215

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 3rd. Grade

College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Disabled

16b. Kind of Business/Industry: Disabled

17. Father's Name (First, Middle, Last): Willie Richardson

18. Mother's Neme (First, Middle, Meiden Surneme): Elizabeth Simms

19a. Informant's Name/Relationship (Type, Print): Lyque Jackson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 3 Hopi Court Randallstown, MD. 21133

20a. Method of Disposition: ☒1 Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Mt. Zion Cemetery

Dete: 02-19-01

20c. Location - City or Town, Stete: Lansdowne, MD

21. Signature of Funeral Service Licensee: Bernard D Johnson

22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)

a. SEPTICEMIA

Due to (or as e consequence of):

b. C.O. PD

Due to (or as e consequence of):

c. DIABETES

Due to (or as e consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant et time of deeth 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Dey Yeer

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probebly 4☐Unknown

24e. Was en autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)

Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Raymond A Nze MD

29c. License number: D34184

29d. Date signed (Month, Dey, Yeer): 2/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAYMOND A. NZE MD, 7801 YORK RD #100, TOWSON MD 21204

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001

32. Registrar's Signature: Bernice G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04340

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Regina Grumbine McQuay
2. Date of Death (Month, Day, Yaar): Feb. 9 2001
3. Time of Death: 6:30AM
4a. Facility Name (If not institution, give street and number): Oak Crest Care Center
4b. City, Town, or Location of Death: Parkville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-20-6200
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct 21 1925
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9110 Naygall Rd
10f. Zip Code: 21234
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): —
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): secretary
16b. Kind of Business/Industry: Olin Matheson

17. Father's Name (First, Middle, Last): George L. Grumbine
18. Mother's Name (First, Middle, Maiden Surname): Marie C. Hart

19a. Informant's Name/Relationship (Type, Print): William S. McQuay, Jr.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9110 Naygall Rd. Baltimore, Md. 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem Gdns — Date: Feb. 13 2001
20c. Location - City or Town, State: Timonium, Md.

21. Signature of Funeral Service Licensee: Krista L. Wells
22. Name and Address of Facility: Evans Funeral Chapel 8800 Harford Rd. Baltimore, Md 21234

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Polyneuropathy — Due to (or as a consequence of): — years.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. — Dua to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Ware autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invasligation 6☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Streat and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the besis of axamination and/or investigation, in my opinion, death occurred al the tima, dale and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Susan G. Weiner MD
29c. Licanse number: D3494/
29d. Dale signad (Month, Day, Year): Feb. 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Susan G. Weiner MD 8800 Walther Blvd Parkville, Md 21234

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001
32. Registrar's Signature: G. Spanier

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

McQuay, Regina 2/9/01

445

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04341

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Elizabeth McDevitt

2. Date of Death (Month, Day, Year): Feb 12 2001

3. Time of Death: 11:20A

4a. Facility Name (If not institution, give street and number): Levindale Geriatric Center

4b. City, Town, or Location of Death: N/A

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220 22 8834

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 29 1915

9. Birthplace (State or Foreign Country): Bel Air, Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore County

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7004 Copeleigh Road

10f. Zip Code: 21212

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married ☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates: X

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Dispatcher

16b. Kind of Business/Industry: Montgomery Ward Co.

17. Father's Name (First, Middle, Last): Joseph Lochary

18. Mother's Name (First, Middle, Maiden Surname): Susan Harkins

19a. Informant's Name/Relationship (Type, Print): Patricia M Nickels (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7004 Copeleigh Road Baltimore, Maryland 21212

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith Data: February 17 2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Heather Hessahn Chojnacki

22. Name and Address of Facility: Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Raymond Miller

29c. License number: D47683

29d. Date signed (Month, Day, Year): 2/12/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Raymond Miller 25 Main Street Suite 200 Reisterstown MD

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Mary McDevitt

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 7 perFH,G792,02/23/01dhb

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04342

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mabel M. Moore
2. Dete of Deeth — Month: February, Day: 12, Year: 2001
3. Time of Deeth: 10:45am
4a Feciity Neme *(If not institution, giva street end number)*: Frederick Villa Nursing Home
4b. City, Town, or Location of Deeth: Catonsville
4c. County of Deeth: Baltimore

Funeral Director

5. Social Security Number: 216-18-6354
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 91 ~~93~~ Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Year)*: Sept. 13,1909
9. Birthplace *(Stete or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Catonsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 711 Academy Road
10f. Zip Code: 21228
10g. Citizan of What Country?: U.S.A.
11. Meritel Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Giva Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Raca - American Indien, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 8; College (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Neme *(First, Middle, Last)*: Howard Towsend
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Bessie Jones
19a. Informant's Name/Relationship *(Type, Print)*: Charlotte Sellers (daughter)
19b. Mailing Address *(Street and Number or Rurel Routa Number, City or Town, Stete, Zip Code)*: 713 Linda Drive Catonsville, Maryland 21228
20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removat from Stete 4☐ Donetion 5☐ Othar *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other place)*: Good Shepherd Cemetery
Dete: Feb.16, 2001
20c. Location - City or Town, Stete: Ellicott City,Maryland
21. Signeture of Funeral Service Licensee: Debra M. Davis
22. Neme end Address of Facility: Witzke Funeral Home, Inc. 1630 Edmondson Ave. Catonsville, Maryland 21228

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode ot dying, such es cardiac or respiretory errest, shock, or heart faiture. List only one cause on eech line. — Approximate Interval Between Onset end Deeth

Immediate Cause (Finat disease or condition resulting in deeth): e. Alzheimer's Dementia — years

Due to (or es e consequence ot):

Sequentially list conditions, if eny, leading to immediate cause. Entar Underlying Cause (Disease or injury that initieted events resulting in death) Last:

b. Due to (or es e consequenca of):

c. Dua to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. **Did tobacco uae contribute to the cause** of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availeble prior to completion of ceuse of deeth? 1☐ Yas 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Homa 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, dete end piece, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, deeth occurred et the tima, dete end pieca, and due to the ceuse(s) end menner stated.

29b. Signeture and title of certifier: M. Deheny MD
29c. Licensa number: D-40521
29d. Date signed *(Month, Dey, Year)*: February 14, 2001

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): DR MAHESH OHANEY — 325 Hospital Drive Suite 103 Glen Burnie, MD 21061

State Registrar

31. Dete filed *(Month, Dey, Year)*: FEB 15 2001
32. Registrer's Signeture: Bonnie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04343

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MICHELE NORRIS
2. Date of Death: Month FEBRUARY Day 11 Year 2001
3. Time of Death: 12:24AM
4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND MEDICAL SYSTEM
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-02-4042
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 34 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 23, 1966
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Arbutus
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: 1104 Oakland Terrace
10f. Zip Code: 21227
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Administrative Assistant
16b. Kind of Business/Industry: Laboratory

17. Father's Name (First, Middle, Last): Clarence Ferguson, Jr.
18. Mother's Name (First, Middle, Maiden Surname): Regina Ferguson

19a. Informant's Name/Relationship (Type, Print): Regina Ferguson, Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5217 4th Street Baltimore, MD. 21225

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery
Date: 2-14-01
20c. Location - City or Town, State: Brooklyn Park, MD

21. Signature of Funeral Service Licensee: Rebecca Robinson
22. Name and Address of Facility: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd, Arbutus, MD. 21227

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. BRADYCARDIA
Due to (or as a consequence of):
b. HYPERKALEMIA
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. NON-HODGKINS LYMPHOMA
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jennifer Morrow, MD RESIDENT PHYSICIAN
29c. License number: AU417643 MD 0082
29d. Date signed (Month, Day, Year): FEBRUARY 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JENNIFER MORROW 22 SOUTH GREENE STREET, BALTIMORE, MD 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04344

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Esther Owens

2. Date of Death: Month Feb Day 12 Year 2001

3. Time of Death: 8:15 PM

4e. Facility Name (If not institution, give street and number): St. Agnes Hospital, 900 Caton Ave.

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 229-22-1876

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 03/23/1923

9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 615 North Woodington Road

10f. Zip Code: 21229

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: Black

15. Decedent's Eduestion (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Day Care Provider

16b. Kind of Business/Industry: Child Care

17. Fether's Neme (First, Middle, Last): Julius Pompey

18. Mother's Neme (First, Middle, Maiden Sumeme): Mary Dingle

19a. Informent's Neme/Reletionship (Type, Print): Lorraine Owens / Daughter

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 7148 N. Alter St., Baltimore, Maryland 21207

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Arbutus Memorial Pk. Cem

Date: 02/17/01

20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signeture of Funeral Service Licensee:

22. Name end Address of Feeility: Derrick C. Jones Funeral Home, 4611 Park Heights Ave., Baltimore, Maryland 21215

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart teilure. List only one ceuse on each line.

Approximete Interval Between Onset and Deeth

Immediete Cause (Finel diseese or condition resulting in deeth)

e. Sepsis — 1 Month

Due to (or as a consequence of):

b. Multi-system failure — 2 Weeks

Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Last

Due to (or es e consequence of):

c. Deep venous thrombosis — ? 1 month

Due to (or es a consequence of):

d. Intra-peritoneal hemorrhages — ? 2 weeks

Pert II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☒ Yes 2☐ No

24b. Were eutopsy findings eveilable prior to completion of ceuse of death? 1☒ Yes 2☐ No

25. Wes cese referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer):

28b. Time of Injury:

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred:

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify):

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete):

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner stated.

29b. Signeture end title of certifier: ▶ W. Raymond Zhu, MD

29c. License number: D0056143

29d. Date signed (Month, Day, Year): 2/13/2001

30. Name and eddress of person who completed ceuse of deeth (Item 23a) (Type, Print): W. RAYMOND ZHU, ST. AGNES HEALTHCARE, 900 CATON AVENUE, BALTIMORE, MD

State Registrar

31. Dete filed (Month, Day, Year): FEB 15 2001

32. Registrer's Signeture: ▶ D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ESTHER OWENS

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04345

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES PETERKIN
2. Date of Death (Month, Day, Year): February 11, 2001
3. Time of Death: 11:48 A.M.
4a. Facility Name (If not institution, give street and number): Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A.

Funeral Director

5. Social Security Number: 250-38-6794
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 72 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): December 24, 1928
9. Birthplace (State or Foreign Country): S.C.

Usual Residence of Decedent

10a. State: md
10b. County: N/A.
10c. City, Town or Location: BALTO.
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1716 N. Washington
10f. Zip Code: 21213
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th grade
College (1-4or 5+): NO
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Construction Worker
16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Jimmy Peterkin
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Davis

19a. Informant's Name/Relationship (Type, Print): Annette Peterkin
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1716 N. Washington St. Balto. MD. 21213

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cem
Date: 2-16-2001
20c. Location - City or Town, State: Landsdown MD.

21. Signature of Funeral Service Licensee: Patricia Betts
22. Name and Address of Facility: Betts Funeral Home 1125 N. Caroline St. Balto. md. 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic Coronary Disease — 20 years
Due to (or as a consequence of):
b. Ischemia — minutes
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. Sudden Death — minutes
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one) Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D0035468
29d. Date signed (Month, Day, Year): February 13, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Horace K. Liang MD 600 North Wolfe St Johns Hopkins Hospital 21287

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04346

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): David Philip Porter
2. Date of Death — Month: Feb. Day: 11 Year: 2001
3. Time of Death: 11:00AM
4a. Facility Name (If not institution, give street and number): 1801 Cox Neck Rd.
4b. City, Town, or Location of Death: Chester
4c. County of Death: Queen Annes

Funeral Director

5. Social Security Number: 212-62-9890
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 48 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 2 1952
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: Queen Annes
10c. City, Town or Location: Chester
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 1801 Cox Neck Rd.
10f. Zip Code: 21619
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): —
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): self employed
16b. Kind of Business/Industry: electrical contractor

17. Father's Name (First, Middle, Last): William F. Porter
18. Mother's Name (First, Middle, Maiden Surname): Joan L. Dance

19a. Informant's Name/Relationship (Type, Print): Sharon L. Porter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1801 Cox Neck Rd. Chester, Md 21619

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bulkley Valley Mem. Gdns. — Date: Feb. 14 2001
20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: Keista S. Wells
22. Name and Address of Facility: Evans Funeral Chapel 2325 York Rd Timonium Md 21093

Physician /Medical Examiner

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Probable Myocardial Infarction — IMMEDIATE

Due to (or as a consequence of):
b. 1

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension
NIDDM
Angina.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one) — Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☒ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D05714
29d. Date signed (Month, Day, Year): 2.12.01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Ralph Libey 204 Medical Center Rd Grasonville, Md 21638

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04347

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ella Lillian Piper
2. Date of Death (Month, Day, Year): Feb. 13, 2001
3. Time of Death: 12:20 pm
4a. Facility Name (If not institution, give street and number): Gilchrist Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 012-10-4000
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 11, 1912
9. Birthplace (State or Foreign Country): Massachusetts

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Reisterstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 109 Nob Hill Park Drive
10f. Zip Code: 21136
10g. Citizen of Whet Country?: U.S.A.

11. Merital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Homemaker

17. Father's Name (First, Middle, Last): Eric Peterson
18. Mother's Neme (First, Middle, Maiden Surname): Jenny Christenson

19a. Informant's Neme/Reletionship (Type, Print): William F. Piper - Son
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 109 Nob Hill Park Dr., Reisterstown, Md. 21136

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Metro Crematory
Dete: Feb. 14, 2001
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: H. Eckhardt
22. Neme end Address of Fecility: Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. 21117

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Piper 2/13/01 12:20pm

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on eech line.

Approximete Intervel Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. multiple Bulbar strokes — months

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b.

Due to (or as e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify): Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the bast of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end piece, end due to the ceuse(s) end menner steted.

29b. Signature and title of certifier: A. Anthony Riley, MD
29c. License number: 025205
29d. Date signed (Month, Day, Year): February 13, 2001

30. Name and address of person who completed cause of death (Item 29a) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Balto. Md 21204

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04348

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William E Porter
2. Data of Death — Month: February Day: 8, Yaar: 2001
3. Tima of Death: 10:50PM
4a. Facility Name *(If not institution, giva street end number)*: Baltimore Rehabilitation and Extended Care
4b. City, Town, or Location of Death: Baltimore
4c. County of Deeth: N/A

Funeral Director

5. Social Security Number: 219 28 7868
6. Sax: 1☐ M 2☐ F — X
7. Aga *(In yrs. last birthday)*: 76 Yrs. — If Under 1 Yaar: Months / Days; If Undar 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: November 9 1924
9. Birthplaca *(Stata or Foraign Country)*: Essex, Maryland

Usual Residence of Decedent

10a. Stata: Maryland
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Insida City Limits: 1☐ Yes 2☐ No — X
10e. Street end Number: 2018 Rocky Point Road
10f. Zip Coda: 21221
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Navar Married 2☐ Married — X 3☐ Widowed 4☐ Divorced
12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yas 2☐ No — If Yas, Give Yaar or Datas: WW II
13. Was Dacedant of Hispanic Origin? (Spacify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.): 1☐ Yes 2☐ No — X — *Specify:*
14. Race - Amarican Indian, Black, Whita, etc. — *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elamantary/Secondary (0-12): 11; Collega (1-4or 5+): N/A
16a. Dacedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use retired)*: Manager
16b. Kind of Businass/Industry: Recreation Business

17. Father's Nama *(First, Middla, Last)*: Joseph J Porter
18. Mother's Nama *(First, Middla, Maidan Surname)*: Effie Tutchton

19a. Informant's Name/Reletionship *(Type, Print)*: Hilda J Porter
19b. Mailing Addrass *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 2018 Rocky Point Road Baltimore, Maryland 21221

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cematary, cremetory or othar placa)*: Parkwood Cemetery February 13 2001 — Data
20c. Location - City or Town, Steta: Baltimore, Maryland

21. Signatura of Funaral Service Licensaa: Martha Rogadn Chomacki
22. Nama and Addrass of Facility: Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or respiratory arrast, shock, or haart failure. List only ona cause on each line.

		Approximate Interval Between Onset and Death
Immediata Causa (Final disaasa or condition resulting in daath)	e. Stroke	6 months
	Dua to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediata causa. Entar Underlying Cause (Disaasa or injury that initiated avants resulting in daath) Last	b. Dua to (or as a consequence of):	
	c. Dua to (or as a consequence of):	
	d.	

Part II. **Othar significant conditions** contributing to daath but not resulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of deeth? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Were autopsy findings available prior to completion of causa of daath? 1☐ Yas 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Placa of Daath *(Chack only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Othar: 4☑ Nursing Homa 5☐ Rasidance 6☐ Other *(Specify)*

27. Manner of Daath: 1☑ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At homa, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To tha bast of my knowledga, daath occurred at the time, data and place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, daath occurred at tha time, data and place, and dua to the ceusa(s) and mannar stated.

29b. Signatura and titla of certifiar: MD
29c. Licansa number: D0032548
29d. Dete signed *(Month, Day, Yaar)*: February 9, 2001

30. Nama and addrass of person who complatad cause of daath (Itam 23a) (Typa, Print): PERRY L COLVIN MD — 10 North Greene Street Baltimore, Maryland

State Registrar

31. Data filad *(Month, Day, Yaar)*: FEB 15 2001
32. Registrar's Signatura: Diane G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04349

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hilda Pernell

2. Data of Death — Month: February Day: 13 Year: 2001

3. Time of Death: 6:21 am

4e. Facility Name (If not Institution, give street and number): Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-36-9955

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 61 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 18, 1939

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1116 Mosher St.

10f. Zip Code: 21217

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, Whita, etc. Specify: African American

15. Decedent's Education (Specify only highast grada completed): Elementary/Secondery (0-12): 7 College (1-4or 5+): 0

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Neme (First, Middle, Last): Clarence E. Henson Sr.

18. Mother's Neme (First, Middle, Maiden Surneme): Margaret Edwards

19a. Informent's Name/Reletionship (Type, Print): Ms. Deborah Henson (daughter)

19b. Mailing Address (Straet and Number or Rural Route Number, City or Town, Stete, Zip Code): 3915 Clarks Lane APT B Balto. Md. 21215

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other piece): Mt. Zion

Date: 2/20/2001

20c. Location - City or Town, State: Lansdowne, Md.

21. Signature of Funaral Servica Licensee: Joseph L. Russ

22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that cabsed the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart ta ure. List only one ceuse on eech line.

Approximate Interval Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in deeth)

a. Arrythmia

Due to (or es a consequence of):

b. Hypertensive Heart Disease

Sequentially list conditions, if any, leeding to immediate causa. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last

Due to (or es a consequence of):

c.

Due to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24e. Wes en autopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yas 2☐ No

25. Was case referred to medical examiner? 1☐ Yas 2☑ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one) 1☑ **Certifying Physician**: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end pleca, and due to the ceuse(s) and menner stated.

29b. Signature and title of certifier:

29c. License number: P 13526

29d. Date signed (Month, Dey, Year): 2/13/01

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Eric Marcalus, M.D. c/o Maryland General Hospital

State Registrar

31. Data filed (Month, Dey, Year): FEB 15 2001

32. Registrar's Signature: Geneva B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Hilda Pernell

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 04350

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Mildred	D.	Pictor	February 11, 2001	7:55 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1414 Front Avenue	Lutherville	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-10-4110	1☐M 2☒F	87 Yrs.			July 4, 1913	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Parkville	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1809 Wentworth Road	21234	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	2	Teacher	Baltimore City School

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Kilgour	Fannie Limekueller

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Marlene Dennstaedt - Niece	1809 Wentworth Road Baltimore, MD 21234

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☒Other (Specify) Entombment	Gardens of Faith	2/15/01	Baltimore, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Christina A. Helton	Baltimcre, MD 21214 Leonard J. Ruck, Inc. 5305 Harford Rd.

Physician /Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. coronary artery disease	30 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

dementia,

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D41104	2-12-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Theodore Houk, MD 7825 York Road Baltimore MD 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 15 2001	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04351

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ESTHER PAULINE QUEEN

2. Date of Death: Month Feb Day 9th Year 2001

3. Time of Death: 9:30 PM

4a. Facility Name (If not institution, give street and number): Mariner of Glen Burnie

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel Co.

Funeral Director

5. Social Security Number: 214-24-2883

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 06 26 1926

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel Co.

10c. City, Town or Location: Severn

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 508 Jones Road

10f. Zip Code: 21144

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic

16b. Kind of Business/Industry: Self-employed

17. Father's Name (First, Middle, Last): unknown

18. Mother's Name (First, Middle, Maiden Surname): Viola Queen

19a. Informent's Name/Relationship (Type, Print): Gertrude Dailey/Sisiter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 508 Jones Road, Severn, Maryland 21144

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Rest Cemetery

Date: 2/15/01

20c. Location - City or Town, State: Hanover, Maryland

21. Signature of Funeral Service Licensee: William C. Brown

22. Name and Address of Facility: William C. Brown Community Funeral Home 1206 W. North Avenue, Baltimore, Maryalnd 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. RESPIRATORY FAILURE — Hours

Due to (or as a consequence of):
b. ASPIRATION PNEUMONIA. — Weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. ADVANCED CHRONIC OBSTRUCTIVE LUNG DISEASE — Years

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS, CARDIAC ARRHYTHMIAS

CONGESTIVE HEART FAILURE. SCHIZOPHRENIA.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R Rangaraju

29c. License number: D54288

29d. Date signed (Month, Day, Year): 12th February 2001

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): RAMASWAMY L RANGARAJU 7441, FURNACE BRANCH ROAD, GLEN BURNIE MD 21060

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001

32. Registrar's Signature: Brenda G Coates

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04352

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Shirley Redd

2. Date of Death — Month: 2 Day: 14 Year: 01

3. Time of Death: 0500

4a. Facility Name *(If not institution, give street and number)*: Genesis Homewood Centa.

4b. City, Town, or Location of Death: Balto. MD.

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217306618

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs, last birthday)*: 73 Yrs. — If Under 1 Yaer: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: 9-9-27

9. Birthplace *(Stata or Foraign Country)*: DC.

Usual Residence of Decedant

10a. Stata: md

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 2638 Kirk Ave.

10f. Zip Code: 21218

10g. Citizan of Whet Country?: U.S.A.

11. Marital Status: 1☒ Nevar Marriad 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Dacedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No — If Yas, Give Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Amarican Indian, Black, Whita, atc. *Specify:* Black

15. Decedent's Education *(Specify only highast grada completed)* — Elamantary/Secondary (0-12): 11th — Collega (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use retired)*: Housekeeping

16b. Kind of Businass/Industry: Hospital

17. Fether's Nama *(First, Middla, Last)*: Arthur Redd

18. Mother's Name *(First, Middla, Maidan Surnama)*: Hester Scott

19a. Informant's Name/Relationship *(Type, Print)*: Florence Stokes / Sister

19b. Mailing Address *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 2638 Kirk Ave - Baltimore, md. 21218

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cematary, cramatory or othar place)*: Mt Zion Cemetery — Data: 2/20/01

20c. Location - City or Town, State: Lansdowne, md.

21. Signature of Funaral Sarvice Licensaa: Ronald Bonatti

22. Nama and Address of Facility: Betts Funeral Home 1129 N. Caroline St - Balto., md 21213

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that causad tha death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona cause on aach line.

Approximata Interval Batwaan Onsat and Daath

Immadiata Causa (Finat disaasa or condition resulting in daath)
e. End stage Renal Disease

Dua to (or as a consaquanca of):

Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Diseasa or injury that Initiated avants resulting in daath) Last
b.

Dua to (or as a consaquanca of):
c.

Dua to (or as a consaquanca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contributa to the causa of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of causa of daath? 1☐ Yas 2☒ No

25. Was casa rafarrad to madical examiner? 1☐ Yes 2☒ No

26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Othar: 4☒ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At home, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

29a. Cartifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurrad at tha tima, data and placa, and dua to the causa(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at the time, date and place, and due to tha causa(s) and mannar stated.

29b. Signatura and titla of cartifiar: Martha C. Raymundo, MD

29c. Licansa number: D54518

29d. Date signed *(Month, Day, Year)*: 2/15/01

30. Nama and addrass of parson who complatad causa of daath (Item 23a) (Type, Print): Martha C. Raymundo 3007 E Northern Parkway Baltimore MD 21214

State Registrar

31. Data filed *(Month, Day, Year)*: FEB 15 2001

32. Registrar's Signatura: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 04353

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
John Joseph Rosche, Jr.	February 11, 2001	3:12a M

4e. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Greater Baltimore Medical Center	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-50-6510	1 ☒ M 2 ☐ F	53 Yrs.			Jan 24 1948	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md	Baltimore	Parkville	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1762 Dunwoody Rd.	21234	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	electronics technician	U.S. Postal Service
12	1		

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John J. Rosche, Sr.	Margaret E. McCourt

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Nancy Rosche	1762 Dunwoody Rd. Baltimore, Md 21234

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Dulaney Valley Mem. Gdns	Feb. 14 2001	Timonium Md

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Tesita S. Wells	Evans Funeral Chapel 8800 Harford Rd. Baltimore, Md 21234

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Rosche, John

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. empyema
Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last
b. metastatic gastric cancer
Due to (or es a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE: 23b. Wes decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel deeth 3 ☐ Ectopic pregnency 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probebly 4 ☒ Unknown

24e. Was en eutopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)
Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Menner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end menner as steted.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ J. Rotolo MD	D38712	2-11-01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Frank S Rotolo 1205 York Rd Lutherville MD

State Registrar

31. Date filed (Month, Day, Yeer)	32. Registrar's Signature
FEB 15 2001	Geneva B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04354

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Agnes Rumiński
2. Date of Death Month: February Day: 10 Year: 2001
3. Time of Death: 7:25AM
4a. Facility Name (If not institution, give street end number): Johns Hopkins Bayview Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 219-18-8663
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 73 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 01/26/1927
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Edgemere
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 4538 Greencove Circle
10f. Zip Code: 21219
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): James Squires
18. Mother's Name (First, Middle, Maiden Surname): Mary Kowalski

19a. Informant's Name/Relationship (Type, Print): Bernice Kirk / Daughter
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 4538 Greencove Circle Edgemere, Maryland 21219

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sacred Heart of Jesus
Date: 02/13/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: David J. Weber
22. Name and Address of Facility: David J. Weber Funeral Homes, P.A. 401 S. Chester Street Baltimore, Maryland 21231

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. (List only one cause on each line.)

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Gastrointestinal bleeding — 3days
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Congestive heart failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: P Morrell MD
29c. License number: 21012
29d. Date signed (Month, Day, Year): February 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Patricia O'Connell, Johns Hopkins Bayview Medical Center, 4940 Eastern Ave Baltimore, MD 21224

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04355

AMENDED ITEM# 18 per fh G792 021501 SS

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kelly Sprwill

2. Data of Death — Month: February Day: 10 Year: 2001

3. Time of Death: 1530

4a. Facility Name (If not institution, give street and number): Bayview Medical Center

4b. City, Town, or Location of Death: BALTO.

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 244-12-6052

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): September 19, 1919

9. Birthplace (State or Foreign Country): N.C.

Usual Residence of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: BALTO.

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 1209 Luzerne Ave

10f. Zip Code: 21213

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 6grade; College (1-4or 5+): NO

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER

16b. Kind of Business/Industry: Westinghouse

17. Father's Name (First, Middle, Last): Lewis Sprwill

18. Mother's Name (First, Middle, Maiden Surname): ~~Bulah~~ Bulah Alston

19a. Informant's Name/Relationship (Type, Print): CLARA Sprwill

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1209 N. LUZERNE AVE BALTO. MD 21213

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Lovly Hill Bapt. Ch. Data: 2-7-2001

20c. Location - City or Town, State: Washington N.C.

21. Signature of Funeral Service Licensee: Patricia Betts

22. Name and Address of Facility: Betts Funeral Home 1129 N. Caroline ST. Balto. MD. 21213

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. massive Cerebral vascular accident — 2 weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Severe Cerebral vascular disease — years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one) — Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Julie E. Martin D.O.

29c. License number: 20323

29d. Date signed (Month, Day, Year): February 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Julie E. Martin D.O. Johns Hopkins Bayview Medical Center, 4940 Eastern Ave, 21224 Baltimore MD

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indellble Ink. Assure All Copies Are Legible.

amend item 20a per fh G792 2/15/01 yf

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04356

Physician /Medical Examiner

1. Decedent's Nama (First, Middle, Last): Robert H. Smith
2. Data of Death (Month, Day, Yaar): January 30, 2001
3. Tima of Death: 551am
4a Facility Nama (If not institution, giva street and number): Maryland General Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death:

Funeral Director

5. Social Security Number: 215-28-0537
6. Sex: 1☑M 2☐F
7. Aga (In yrs. last birthday): 69 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year):
9. Birthplece (State or Foraign Country):

Usual Rasidance of Dacedant

10a. Stata: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Insida City Limits: 1☑Yas 2☐No
10e. Street and Number: 538 McMechen
10f. Zip Code: 21217
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☑Navar Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedant Evar in U.S. Armed Forcas? 1☐Yas 2☑No If Yas, Giva Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐Yas 2☑No Specify:
14. Race - Amarican Indian, Black, Whita, atc. Specify: Black

15. Decedant's Educetion (Specify only highast grada completad): Elamentary/Secondary (0-12): 12th Grade; Collega (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): Truck Driver
16b. Kind of Businass/Industry: Transportation

17. Fathar's Nama (First, Middla, Last): Marcus Smith
18. Mothar's Nama (First, Middla, Maidan Sumama): Sadie Kelly

19a. Informant's Name/Relationship (Type, Print): Marquette L. Nelson / Niece
19b. Mailing Address (Straat and Numbar or Rural Route Number, City or Town, State, Zip Coda): 538 McMechen Baltimore, MD. 21217

20a. Method of Disposition: 2☑Cramation 3☐Ramoval from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Nama of cemetary, cramatory or othar placa): Metro Crematory
Dete: 2/5/01
20c. Location - City or Town, Stata: Catonsville, MD.

21. Signature of Funaral Sarvica Licensaa: Vaughn C Fuerst
22. Nama and Addrass of Facility: Cremation Services. P.A. 5151 Balto. Nat'l Pike Balto. MD. 21229

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused tha daath. Do not antar tha moda of dying, such es cardiac or respiratory arrest, shock, or haart feilure. List only one ceuse on eech line. Approximete Intervel Between Onsat and Daath

Immediata Causa (Final disaasa or condition resulting in daath): a. Intracerebral Hemorrhage
Dua to (or as a consaquance of):
Sequentially list conditions, if any, laeding to immadiate causa. Entar Underlying Cause (Disaasa or injury that initiated evants resulting in death) Last:
b. Dua to (or as a consequance of):
c. Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the cauae of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☐Yas 2☑No
24b. Were autopsy findings available prior to complation of causa of death? 1☐Yas 2☐No

25. Was cesa rafarred to medical examinar? 1☐Yas 2☑No
26. Placa of Daath (Check only ona) Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Othar: 4☐Nursing Homa 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Neturel 2☐Accident 3☐Suicida 4☐Homicida 5☐Pending invastigation 6☐Could not be datarminad
28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)
28b. Tima of Injury
28c. Injury at Work? 1☐Yas 2☐No
28d. Dascribe how injury occurred
28e. Dete of Injury (Month, Day Year)
28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1☑**Certifying Physician**: To tha best of my knowledge, deeth occurred at tha tima, data and place, end due to tha causa(s) and mannar es stated. 2☐**Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at the time, date and place, end due to the cause(s) and mannar statad.

29b. Signatura and titla of cartifier: MD
29c. Licansa number: P 14573
29d. Data signad (Month, Day, Year): 1/30/01

30. Nama and addrass of person who completed ceusa of daath (Item 23a) (Type, Print): Scott Cardone, M.D. c/o Maryland General Hospital

State Registrar

31. Data filed (Month, Day, Year): FEB 15 2001
32. Registrar's Signatura: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Robert Smith

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM# 10e per fh G792 021501 SS

Certificate of Death

Reg. No. 2001 04357

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Charles Donald Speer

2. Date of Deeth — Month: Feb. 14, Dey/Yeer: 2001

3. Time of Death: 9 a.m.

4a. Facility Name *(If not institution, give street end number)*: 8802 Joshua Court

4b. City, Town, or Location of Death: Pikesville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 288-38-2236

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 58 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: Sept. 22, 1942

9. Birthplace *(Stete or Foraign Country)*: Ohio

Usuel Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Pikesville

10d. Insida City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: ~~288-38-2236~~ 8802 Joshua Court

10f. Zip Code: 21208

10g. Citizen of Whet Country?: U.S.A.

11. Maritel Status: 1 [ ] Never Merried 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Evar in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 — College (1-4or 5+): 6

16e. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Systems Analyst

16b. Kind of Business/Industry: Sceial Security Adm.

17. Fathar's Neme *(First, Middle, Last)*: Thomas Edgar Speer

18. Mother's Name *(First, Middle, Maiden Sumema)*: Nina Dunne

19e. Informant's Name/Relationship *(Type, Print)*: Nellie R. Pena-Speer - Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 8802 Joshua Ct., Pikesville, Md. 21208

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from Stete 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Piece of Disposition *(Nema of cemetery, cremetory or other piece)*: Metro Crematory — Date: Feb. 16, 2001

20c. Location - City or Town, Steta: Baltimore, Md.

21. Signature of Funeral Service Licensee: H. Eckhardt

22. Name and Address of Fecility: Eckhardt Funeral Chapel 21117, 11605 Reisterstown Rd., Owings Mills, Md.

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one ceuse on eech line.

Approximeta Interval Between Onset end Death

Immediate Ceuse (Finel diseese or condition resulting in deeth)

a. Tracheobronchitis

Due to (or es a consequence of):

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

Alzheimer's Disease

Parkinson's Disease

23b. Did tobacco use contributa to the cause of death? 1 [ ] Yes 2 [/] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an eutopsy performed? 1 [ ] Yes 2 [/] No

24b. Were eutopsy findings availabla prior to completion of cause of death? 1 [ ] Yes 2 [/] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [/] No

26. Piece of Deeth *(Check only one)*: Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [/] Residence 6 [ ] Other *(Specify)*

27. Menner of Deeth: 1 [/] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1 [/] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) and manner stated.

29b. Signature end title of certifier

29c. License number: D27123

29d. Date signed *(Month, Dey, Year)*: 2/14/01

30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print): Judith Arnold 70 Main St Reisterstown md 21136

State Registrar

31. Dete filed *(Month, Dey, Year)*: FEB 15 2001

32. Registrer's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

4

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04358

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EDWARD GARLAND SAMUEL

2. Date of Death: Month FEB. Day 13 Year 2001

3. Time of Death: 8:24 A.M.

4a. Facility Name (If not institution, give street and number): OAKCREST CARE CENTER

4b. City, Town, or Location of Death: PARKVILLE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 212-01-7926

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 1/13/1913

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: PARKVILLE

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 8810 WALTHER BLVD. CALVERT CT. 223

10f. Zip Code: 21234

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8TH GRADE | College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SALESMAN

16b. Kind of Business/Industry: INSURANCE

17. Father's Name (First, Middle, Last): JOSEPH SAMUEL

18. Mother's Name (First, Middle, Maiden Surname): AMY PETTY

19a. Informant's Name/Relationship (Type, Print): ANN SAMUEL WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8810 WALTHER BLVD. CALVERT CT. 223 PARKVILLE, MD 21234

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY, INC. Date: 2/14/01

20c. Location - City or Town, State: CATONSVILLE, MD

21. Signature of Funeral Service Licensee: M. Neal Coleman

22. Name and Address of Facility: THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — 6 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Congestive Heart Failure, Dementia, Anemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Susan G Weiner MD

29c. License number: D34941

29d. Date signed (Month, Day, Year): Feb. 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Susan G. Weiner MD 8800 Walther Blvd Parkville, Md 21234

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04359

amend item 20b per fh G792 2/15/01 yf

10pm

Stewart, Pearl February 11, 2001

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Pearl A. Stewart
2. Data of Death Month: 2 Day: 11 Year: 2001
3. Time of Death: 10:00 pm
4a. Facility Name (If not institution, give street and number): Gilcrest Hospice
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-20-6644
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 8-23-1926
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Woodlawn
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1512 Kirkwood Rd.
10f. Zip Code: 21207
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic
16b. Kind of Business/Industry: Home Care Aid

17. Father's Name (First, Middle, Last): Leroy Stewart
18. Mother's Name (First, Middle, Maiden Surname): Viola Taft

19a. Informant's Name/Relationship (Type, Print): Lorchid Stewart / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1512 Kirkwood Ave Balto. MD. 21207

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Cemetery | Date: 2/17/01
20c. Location - City or Town, State: Owings Mills, MD.

21. Signature of Funeral Service Licensee: Vaughn C Greene
22. Name and Address of Facility: Vaughn C. Greene Funeral Services 5151 Balto. Nat'l Pike Balto. MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Lung Cancer — 6 months
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: W. Anthony Riley, MD
29c. License number: D25205
29d. Data signed (Month, Day, Year): February 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Balto. MD 21204

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001
32. Registrar's Signature: G. Sparks

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

9

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04360

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Doris Smith
2. Date of Deeth — Month: February Dey: 7 Year: 2001
3. Time of Death: 821 pm
4e. Facility Neme *(If not institution, give street end number)*: Maryland General Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-26-3273
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthdey)*: 70 Yrs. — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Year)*: Dec. 11, 30
9. Birthplece *(Stete or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Insida City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 1809 Clifton Ave.
10f. Zip Code: 21217
10g. Citizen of Whet Country?: USA

11. Marital Stetus: 1☐ Never Married 2☒ Merried 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No *Specify:*
14. Race - American Indian, Bleck, White, etc. *Specify:* African American

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 0
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Fether's Neme *(First, Middle, Last)*: Henry Smith
18. Mother's Name *(First, Middle, Maiden Surneme)*: Anita Watkins

19e. Informent's Neme/Reletionship *(Type, Print)*: Mr. Elmer T. Smith (Husband)
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 1809 Clifton Ave. Balto. Md. 21217

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from Stata 4☐ Donetion 5☐ Other *(Specify)*
20b. Placa of Disposition *(Neme of cemetery, cremetory or other piece)*: New Cathedral — Date: 2/12/2001
20c. Location - City or Town, State: Balto. Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Feility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset end Death

Immediate Cause (Final diseese or condition resulting in deeth)
e. Coronary Artery Disease — many years
Due to (or as e consequence of):
Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Diseese or injury thet initieted events rasulting in deeth) Lest
b. Diabetes Mellitus — years
Due to (or as a consequenca of):
c. Hypertension
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypothyroidism

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At homa, farm, straet, factory, office building, etc. *(Specify)*
28f. Location *(Straat end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigetion, in my opinion, deeth occurred et the time, date end pleca, end due to the cause(s) end menner stated.

29b. Signatura and titla of certifier: Christie Lamping D
29c. License number: D32263
29d. Date signed *(Month, Dey, Year)*: 2/9/2001

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): CHRISTIE LAMPING 2000 WEST BALTIMORE 21223

State Registrar

31. Dete filed *(Month, Dey, Year)*: FEB 15 2001
32. Registrar's Signetura: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04361

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): J. Leroy Scott
2. Date of Death (Month, Day, Year): February 3, 2001
3. Time of Death: 9:45 PM
4a. Facility Name (If not institution, give street and number): Saint Joseph Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-09-0761
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 29, 1910
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1525 E. North Ave.
10f. Zip Code: 21213
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+): 8
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Crane Operator
16b. Kind of Business/Industry: Bethlehem Steel

17. Father's Name (First, Middle, Last): David Scott
18. Mother's Name (First, Middle, Maiden Surname): Mamie Wilson

19a. Informant's Name/Relationship (Type, Print): Mrs. Barbara Strickland (niece)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 904 Barebranch Ct. Balto. Md. 21208

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Mem. Park | Date: 2/8/2001
20c. Location - City or Town, State: Balto. Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. UROSEPSIS — 6 days

Due to (or as a consequence of):
b. INSULIN DEPENDENT DIABETES MELLITUS — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. CONGESTIVE HEART FAILURE — years
Due to (or as a consequence of):
d. ANEMIA DUE TO RENAL FAILURE — years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
MONOCLONAL GAMMOPATHY
PHARYNGEAL DYSPHAGIA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ceballos, MD
29c. License number: D25886
29d. Date signed (Month, Day, Year): FEB. 12 - 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LILIA CEBALLOS, M.D. - 7601 - OSLER DRIVE - TOWSON, MD 21204

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04362

AMEND#7 PER F.H. G792 2-15-2001 JAB

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Barbara Singleton

2. Date of Death: Month February Dey 6 Yeer 2001

3. Time of Death: 5:30PM

4a. Facility Name (If not institution, give street and number): Good Samaritan

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 169-32-3046

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): ~~63~~ 62 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): 10-8-1938

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. Stete: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 1453 Kitmore

10f. Zip Code: 21239

10g. Citizen of Whet Country? USA

11. Meritel Stetus: 1☐ Never Merried 2☑ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): UKN.

16b. Kind of Business/Industry: UKN.

17. Father's Neme (First, Middle, Last): Richard gilbert

18. Mother's Neme (First, Middle, Maiden Surneme): Louise

19a. Informent's Neme/Reletionship (Type, Print): James Singleton-husband

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1453 Kitmore Baltimore, maryland 21239

20a. Methed of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Mt. Zion Cemetery Date: 2/12/2001

20c. Location - City or Town, Stete: Baltimore, maryland

21. Signeture of Funeral Service Licensee: Geoffrey Miller

22. Neme end Address of Feciliity: Miller's metropolitan Chapel 1639. Broadway 21213

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in deeth)
a. Cardiac arrhythmia

Due to (or es a consequence of):
b. severe aortic Regurgitation

Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in death) Last
c. CRF.

Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.
- COPD
- HTN

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Was cese referred to medicel exeminer? 1☑ Yes 2☐ No

26. Place of Deeth (Check only one): Hospitel: 1☐ Inpetient 2☒ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: MD

29c. License number: D41536

29d. Date signed (Month, Dey, Year): 2/7/01

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Anisa MSR24 5600 Loch Raven Blvd, Balt MD 21239

State Registrar

31. Dete filed (Month, Day, Year): FEB 15 2001

32. Registrer's Signeture: Bonnie B Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

2001 04363 Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARION SEIBERT
2. Date of Death (Month, Day, Year): FEBRUARY 09 2001
3. Time of Death: 12:35 PM
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS BAYVIEW MEDICAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-01-9215
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 18, 1910
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1713 Woodland Drive
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 6 Years
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Packer
16b. Kind of Business/Industry: Allied Chemical Co.

17. Father's Name (First, Middle, Last): Joseph Cacace
18. Mother's Neme (First, Middle, Meiden Surname): Theresa Goetzinger

19a. Informant's Name/Reletionship (Type, Print): Mr. Bernard E. Seibert (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1713 Woodland Drive Dundalk, Maryland 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other place): Most Holy Redeemer Cem.
Dete: 2/13/2001
20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Grego E. Ruck
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. PNEUMONIA — Approximate Interval Between Onset and Death: TWO DAYS

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Wes decedent pregnent in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetel deeth 3☐ Ectopic pregnancy 4☐ Pregnant et time of death 5☐ Other (specify) 9☐ Unknown
23d. Dete of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probebly 4☐ Unknown
24a. Was en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end manner as steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated.
29b. Signature and title of certifier: Timothy Ta 12013
29c. License number: 76S-000
29d. Date signed (Month, Dey, Yeer): FEBRUARY 13, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type/ Print): Timothy Ta M.D. 4940 Eastern Avenue Baltimore, Maryland 21224

State Registrar

31. Date filed (Month, Dey, Yeer): FEB 15 2001
32. Registrar's Signature: D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Physitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturel", or itame 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: 23A PER PHY G792 2-15-01 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04364

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Mary Caroline Stahl	February 11, 2001	1:30 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Manor Care Health	Rossville	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-38-6149	1☐ M 2☒ F	81 Yrs.			May 11, 1919	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Edgemere	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
7603 Old Road Bay Front	21219	United States

11. Merital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12 Years		Homemaker	Own Home

17. Father's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
Casper Reuter	Sarah Konig

19a. Informant's Neme/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code)
Son Mr. Robert M. Stahl, III	6505 Hazelwood Ct. Baltimore, Maryland 21237

20a. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other pleca)	Date	20c. Location - City or Town, State
☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)	Oak Lawn Cemetery	2/13/2001	Baltimore, Maryland

21. Signature of Fubersl Service Licensee ▶ Robert M. Stahl

22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc
7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23e. Pert I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

		Approximate Interval Between Onset end Death
Immediate Ceuse (Finel disease or condition resulting in death)	a. PNEUMONIA ASPIRATION ~~Pneumonia due to aspiration~~	10 days
	Due to (or as e consequence of):	
Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or es e consequence of):	
	d.	

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CVA, Chronic Left Leg Cellulitis, Dehydration

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings eveilable prior to completion ot cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☑ No

25. Was case referred to medical exeminer?	26. Place of Deeth (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ tnpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) end menner as steted.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶ MD	D-38754	02-12-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MALIKA WASEEM. 709. EASTERN BLVD. MD - 21221

State Registrar

31. Dete filed (Month, Dey, Year)	32. Registrar's Signature
FEB 15 2001	▶ Penny D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04365

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Richard Freeman Serfas, Sr.

2. Date of Death (Month, Day, Year): February 10, 2001

3. Time of Death: 11:41 AM

4a. Facility Name (If not institution, give street and number): Joseph Richey Hospice

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 162-24-0814

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 2, 1929

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 730 Bethnal Road

10f. Zip Code: 21229

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Brakeman

16b. Kind of Business/Industry: Railroad

17. Father's Name (First, Middle, Last): Jacob F. Serfas

18. Mother's Name (First, Middle, Maiden Surname): Helen M. Oles

19a. Informant's Name/Relationship (Type, Print): Louise M. Serfas / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 730 Bethnal Road Baltimore, Maryland 21229

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): New Cathedral Cemetery

Date: 2/14/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: David J. Weber

22. Name and Address of Facility: David J. Weber Funeral Homes, P.A. 5311 Edmondson Avenue Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic cancer of rectum — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Diarrhea and wasting — 2 months

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Richey Hospice

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [illegible] Powell M.D.

29c. License number: D13006

29d. Date signed (Month, Day, Year): 2/11/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Thomas Powell, 101 W. Read St 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001

32. Registrar's Signature: [illegible] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

2/10/01 11:41 AM

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Richard Serfas

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04366

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Clifford F. Travis

2. Date of Death Month Day Year: Feb. 14, 2001

3. Time of Death: 7:30 A.M.

4a. Facility Name *(If not institution, give street and number)*: Cranberry Cottage Hospice Nursing Home

4b. City, Town, or Location of Death: Pasadena

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 189-28-7539

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 94 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 18, 1906

9. Birthplace *(State or Foreign Country)*: England

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 1480 Thies Drive

10f. Zip Code: 21122

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Engineer

16b. Kind of Business/Industry: General Electric

17. Father's Name *(First, Middle, Last)*: Clayton Robert Travis

18. Mother's Name *(First, Middle, Maiden Surname)*: Agnes Thompson

19a. Informant's Name/Relationship *(Type, Print)*: Marguerite R. Travis (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1480 Thies Drive Pasadena, Maryland 21122

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Greenmount Crematory — Date: 2/15/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: John F. Collins

22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 3204 Mountain Rd. Pasadena, MD. 21122

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only* one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Myocardial infarction — One week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: 018508

29d. Date signed *(Month, Day, Year)*: 02-15-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles J. Wu, MD, 1600 S. Crain Hwy. Ste. 106, Glen Burnie, MD 21061

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 15 2001

32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04367

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Vivian Thornton
2. Date of Death (Month, Day, Year): February 11, 2001
3. Time of Death: 8:04 AM
4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 216-28-2601
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10-23-30
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1510 N. Ellwood Avenue
10f. Zip Code: 21213
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th Grade | College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cashier
16b. Kind of Business/Industry: Washington Street Spirits

17. Father's Name (First, Middle, Last): William J. Thornton
18. Mother's Name (First, Middle, Maiden Surname): Priscilla B. Satchell

19a. Informant's Name/Relationship (Type, Print): Sharon W. Jones
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 304 B. Delancey Place Mt. Laurel, NJ 08054

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Mem. Pk. Cem. | Date: 02-17-01
20c. Location - City or Town, State: Arbutus, MD

21. Signature of Funeral Service Licensee: Bernard D Johnson
22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Pneumonia	Weeks
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	Metastatic Non-small Cell carcinoma	months
Due to (or as a consequence of):		
c.	Breast Cancer	Years
Due to (or as a consequence of):		
d.	Uterine Cancer	Years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Lymphangitic spread of non-small cell carcinoma

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Amy E. Spooner, M.D.
29c. License number: RES-000
29d. Date signed (Month, Day, Year): February 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Amy E. Spooner, M.D. Johns Hopkins Hospital, Tower 110, 600 North Wolfe Street, Baltimore, MD 21287

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04368

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Grace Virginia Terry

2. Date of Death (Month, Day, Year): Feb 10 2001

3. Time of Death: 11:00AM

4a. Facility Name (If not institution, give street and number): Saint Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-20-2248

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 1, 1918

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Lansdowne

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3 Silinton Rd. Apt. 2D

10f. Zip Code: 21227

10g. Citizen of Whet Country?: U.S.A.

11. Maritel Status: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Neme (First, Middle, Last): James Bennett Branham

18. Mother's Name (First, Middle, Maiden Surname): Minnie Virginia Johns

19a. Informant's Neme/Relationship (Type, Print): NeVille Terry, husband

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 3 Silinton Rd. Apt. 2D Lansdowne, MD. 21227

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from Stata 4☐ Donetion 5☐ Other (Specify)

20b. Pleca ol Disposition (Neme of cemetery, crematory or othar placa): Glen Haven Memorial Park

Date: 2-13-01

20c. Location - City or Town, Stete: Glen Burnie, MD

21. Signature of Funaral Service Licensee: Rebecca Robinson

22. Nama and Address of Facility: Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne, MD. 21227

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in deeth)

a. Septicemia Staphylococcal — 2weeks

Due to (or as e consequenca of):

b. ASPIRATION PNEUMONIA — 2weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last

Due to (or as e consequenca of):

c.

Due to (or as e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Deeth (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Mennar of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Pleca ol Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred et the time, date and plece, end due to the cause(s) end menner as stated. 2☐ **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and plece, end due to the cause(s) and menner steted.

29b. Signature end title of certifier: Rani S. Karpineni MD

29c. License number: D26307

29d. Date signed (Month, Day, Year): 2/10/01

30. Nema and addrass of parson who completed causa of death (Item 23a) (Type, Print): RANI S. KARPINENI 4000 ANNAPOLIS RD, BALTIMORE, MD 21227

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

NAME GRACIE V. TERRY

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04369

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William Eugene Tone
2. Date of Death (Month, Day, Year): February 12 2001
3. Time of Death: 2:40am
4a. Facility Name *(If not institution, give street and number)*: 6335 Greenfield Road unit 1709
4b. City, Town, or Location of Death: Elkridge
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 081-05-5364
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 93 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan 24, 1908
9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Elkridge
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 6335 Greenfield Road, Unit 1709
10f. Zip Code: 21075
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Insurance Adjuster
16b. Kind of Business/Industry: Insurance

17. Father's Name *(First, Middle, Last)*: William Tone
18. Mother's Name *(First, Middle, Maiden Surname)*: Maargaret Dennin

19a. Informant's Name/Relationship *(Type, Print)*: Carol Ann Bachman / daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6335 Greenfield Road, Unit 1709, Elkridge, Maryland 21075

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Maryland Veterans Cem.
Date: 2/14/01
20c. Location - City or Town, State: Garrison, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Delay Deation
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I: dementia (Alzheimers
hypo thyroidism

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [✓] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D31322
29d. Date signed *(Month, Day, Year)*: 2/13/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 716 Maiden CHOICE LN. CATONSVILLE, MD 21228

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 15 2001
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04370

Physician /Medical Examiner

1. Decedent's Nama (First, Middle, Last): Kenneth C. Towle

2. Data of Daath — Month: Jan Day: 14 Yaar: 2001

3. Tima of Death: 1240 pm

4a. Facility Nema (If not institution, giva street end numbar): Long View Nursing Home

4b. City, Town, or Location of Deeth: Manchester

4c. County of Death: Carroll

Funeral Director

5. Social Security Numbar: 004-16-5425

6. Sax: 1 [X] M 2 [ ] F

7. Aga (In yrs. last birthday): 84 Yrs.

If Under 1 Yaar — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Data of Birth (Month, Dey, Year): Jan. 10, 1917

9. Birthplace (Stata or Foraign Country): Augusta, Maine

Usual Rasidanca of Dacedant

10a. Stata: Maryland

10b. County: Carroll

10c. City, Town or Location: Manchester

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3346 Kensigton Square

10f. Zip Coda: 21102

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1 [ ] Navar Married 2 [X] Married 3 [ ] Widowad 4 [ ] Divorced

12. Was Dacedant Evar in U.S. Armed Forcas? 1 [X] Yas 2 [ ] No If Yas, Giva Yaar or Datas: W.W.II

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1 [ ] Yas · 2 [X] No Specify:

14. Raca - Amarican Indien, Black, Whita, atc. Spacify: White

15. Dacadent's Education (Specify only highast grada completad)

Elamentary/Secondary (0-12): 12

Collaga (1-4or 5+): +4

16a. Dacedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa ratired): Guidance Counselor

16b. Kind of Businass/Industry: Baltimore Co. Board of Ed.

17. Fathar's Nama (First, Middle, Last): Arthur Towle

18. Mother's Nama (First, Middla, Maiden Sumama): Marion Chadwick

19a. Informant's Name/Relationship (Type, Print): Mary Elizabeth Towle - wife

19b. Mailing Addrass (Streat and Number or Rural Route Number, City or Town, Stata, Zip Code): 3346 Kensigton Square Manchester, Md. 21102

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar (Specify)

20b. Placa of Disposition (Neme of cematary, cramatory or othar place): Lakeview Mem. Park

Dete: Feb. 17, 2001

20c. Locatlon - City or Town, State: Sykesville, Md.

21. Signature of Funaral Sarvice Licansaa: Justin R. Eckhardt

22. Nama end Addrass of Facility: Eckhardt Funeral Chapel, P.A. 3296 Charmil Dr. Manchester, Md. 21102

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that causad tha daath. Do not antar the moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ona ceuse on eech line.

Approximata Intarval Batwaen Onsat and Daath

Immadiata Ceusa (Final disaasa or condition resulting in daath)

e. COPD — Dua to (or as a consequanca of):

Sequantially list conditions, if any, laading to immadieta causa. Entar Underlying Causa (Diseesa or injury that initieted events resulting in daath) Last

b. — Due to (or as a consaquance of):

c. — Dua to (or es a consequence of):

d.

Part II. **Other significant conditiona** contributing to death but not rasulting in tha undarlying ceusa givan in Part I.: Diabetes mellitus

23b. Did tobecco use contribute to the cauaa of deeth? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performad? 1 [ ] Yes 2 [X] No

24b. Wara autopsy findings availabla prior to complation of ceusa of daath? 1 [ ] Yas 2 [X] No

25. Was case refarrad to medical examinar? 1 [ ] Yes 2 [X] No

26. Placa of Daath (Check only ona)

Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA

Othar: 4 [X] Nursing Homa 5 [ ] Residanca 6 [ ] Other (Spacify)

27. Manner of Death: 1 [X] Naturel 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding investigation 6 [ ] Could not be determined

28a. Deta of Injury (Month, Day Year)

28b. Tima of Injury: M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurrad

28a. Placa of fnjury - At home, farm, straet, factory, office building, atc. (Spacify)

28f. Location (Street and Number or Rural Routa Numbar, City or Town, Steta)

29a. Certifiar (Check only one): 1 [X] **Certifying Physicien:** To tha bast of my knowledga, death occurred at the time, data and plece, end dua to tha cause(s) end mennar as stated. 2 [ ] **Medical Examiner:** On the basis of axaminetion and/or Invastigation, in my opinion, daath occurred at tha tima, data and place, and due to tha causa(s) and manner stated.

29b. Signature and title of certifier: [illegible] MD

29c. Licansa number: D33165

29d. Deta signed (Month, Day, Year): 2/14/01

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Steven Shaffer 2111 Hanover Pike Hampstead 21074

State Registrar

31. Data filad (Month, Day, Year): FEB 15 2001

32. Registrar's Signatura: Geneva G Sparks

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

55

12

01-0808-510
jhm
MYRTICE
TILLER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEMS# 23,27,&28a-f per ME 6/7/2001 SS

Certificate of Death

Reg. No. 2001 04371

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Myrtice Tiller

2. Date of Death Month Day Yeer: FEBRUARY 13, 2001

3. Time of Death: 05:28 AM

4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 259-64-1615

6. Sex: 1☐M 2☑F

7. Age (In yrs. last birthday): 59 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Yeer): 9-2-1941

9. Birthplece (State or Foreign Country): GA.

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☑Yes 2☐No

10e. Street end Number: 2923 Silver Hill Ave

10f. Zip Code: 21207

10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☑Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☑No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☑No Specify:

14. Rece - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th Grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): House Keeping

16b. Kind of Business/Industry: Hospital

17. Father's Name (First, Middle, Last): Willie Eberhart

18. Mother's Name (First, Middle, Maiden Surname): Viola She.

19a. Informant's Name/Relationship (Type, Print): Fannie Mosby | sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 2923 Silver Hill Ave Balto. MD. 21207

20a. Method of Disposition: 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): King Park Cemetery

Date: 2/ |01

20c. Location - City or Town, Stete:

21. Signature of Funeral Service Licensee: Vaughn C Greene

22. Name and Address of Facility: Vaughn C Greene Funeral Serv. 5151 Balto. Nat'l Pike Balto. MD. 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each fine.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ACUTE COCAINE AND NARCOTIC INTOXICATION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☑Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent et time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

28. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined

28a. Date of Injury (Month, Day Yeer) found: 2-13-01

28b. Time of Injury found: unknown M

28c. Injury at Work? 1☐Yes 2☒No

28d. Describe how injury occurred: unknown

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify): found at home

28f. Location (Street and Number or Rural Route Number, City or Town, Stete): 2923 Silver Hill Ave., Balto., MD

29a. Certifier (Check only one) 1☐Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner es stated. 2☒Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dennis J Clute M.

29c. License number: OCME

29d. Date signed (Month, Day, Year): FEBRUARY 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis Chute MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001

32. Registrar's Signature: Donna L Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04372

* Turner, Herbert R.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last): HERBERT RUSSELL TURNER		2. Date of Death (Month, Day, Year): February 11 2001	3. Time of Death: 5:25 pm
4a. Facility Name (If not institution, give street and number): North Arundel Hospital	4b. City, Town, or Location of Death: Glen Burnie	4c. County of Death: Anne Arundel	
5. Social Security Number: 219-05-0862	6. Sex: 1☒ M 2☐ F	7. Age (In yrs. last birthday): 86 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)	8. Date of Birth (Month, Day, Year): MAR. 9, 1914
9. Birthplace (State or Foreign Country): MARYLAND			

Usual Residence of Decedent

10a. State: MARYLAND	10b. County: ANNE ARUNDEL	10c. City, Town or Location: GLEN BURNIE	10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 102 CRAIN HIGHWAY APT. 894	10f. Zip Code: 21061	10g. Citizen of What Country?: U.S.A.	

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? ☒ Yes 2☐ No If Yes, Give Year or Dates: 1942-1945	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:	14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4or 5+):	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TRUCK DRIVER	16b. Kind of Business/Industry: TRANSPORTATION	
17. Father's Name (First, Middle, Last): HERBERT TURNER	18. Mother's Name (First, Middle, Maiden Surname): FLORANCE WARFIELD		
19a. Informant's Name/Relationship (Type, Print): MRS. HAZEL MARVEL (SISTER)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 200 NORMAN AVENUE, GLEN BURNIE, MD. 21060		
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place): NICHOLS BETHEL CHURCH CEMETERY	Date: 02/15/2001	20c. Location - City or Town, State: ODENTON, MD.
21. Signature of Funeral Service Licensee: ▶ [signature]	22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061		

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
e. ADULT RESPIRATORY DISTRESS SYNDROME — 7 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature], MD

29c. License number: D46962

29d. Date signed (Month, Day, Year): FEBRUARY 11, 2001.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M. SHIRAZI, M.D. NORTH ARUNDEL HOSPITAL. MD 21061.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001	32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04373

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Lest)*: QUEEN E. THOMPSON
2. Date of Deeth Month / Day / Year: 02/12/2001
3. Time of Death: 8:00 AM
4a. Fecility Neme *(If not institution, give street end number)*: SAINT AGNES
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 250 46 5034
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. lest birthday)*: 69 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 12/29/31
9. Birthplece *(State or Foreign Country)*: N.C.

Usual Residence of Decedent

10a. State: MD.
10b. County:
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 802 N. HILTON ST.
10f. Zip Code: 21229
10g. Citizen of Whet Country?: USA
11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Bleck, White, etc. *Specify:* AFRO AMERICAN
15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+): 0
16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER
16b. Kind of Business/Industry: HOME
17. Father's Neme *(First, Middle, Lest)*: ERNEST WEBB
18. Mother's Neme *(First, Middle, Maiden Sumeme)*: QUEEN OLLIE THOMPSON
19e. Informant's Name/Relationship *(Type, Print)*: KIM HOLEMAN
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 7405 BROMPTON RD. BALTO. MD. 21207
20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, crematory or other place)*: ARBUTUS PARK
Dete: 2/17/01
20c. Location - City or Town, State: ARBUTUS, MD.
21. Signature of Funeral Service Licensee: CECIL A. ESTEP Cecil A Estep
22. Name and Address of Facility: ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PL. BALTO. MD. 21217

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

		Approximete Interval Between Onset end Deeth
Immediete Ceuse (Final disease or condition resulting in death) e.	Acute Myocardial infarction	1 Hr.
Due to (or es a consequence of):	HTN	Yrs.
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Lest b.		
Due to (or es a consequence of):		
c.		
Due to (or as e consequence of):		
d.		

Part II. **Other significant conditione** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. **Did tobacco use contribute to the cause of deeth?** 1☐ **Yes** 2☐ **No** 3☐ **Probably** 4☑ **Unknown**

24a. Was en eutopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings aveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Yeer)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: Attending MD
29c. License number: D36942
29d. Date signed *(Month, Dey, Yeer)*: February 14, 2001

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print): B. TURAKHIA, MD 1009 Frederick Rd. Catonsville, MD 21228

State Registrar

31. Dete filed *(Month, Day, Year)*: FEB 15 2001
32. Registrer's Signature: G Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04374

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GEORGE L. VRANAS

2. Date of Death (Month, Day, Year): FEBRUARY 12, 2001

3. Time of Death: 2:51 AM

4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: AA COUNTY

Funeral Director

5. Social Security Number: 213-12-2890

6. Sex: X M 2 F

7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): OCT. 10, 1920

9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: GLEN BURNIE

10d. Inside City Limits: 1 Yes 2 X No

10e. Street and Number: 204 SANDSBURY ROAD

10f. Zip Code: 21061

10g. Citizen of Whet Country?: U.S.A.

11. Meritel Stetus: 1 Never Married 2 Married 3 Widowed 4 X Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:

14. Race - American Indien, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 3 | College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): BUILDER

16b. Kind of Business/Industry: CONSTRUCTION

17. Father's Neme (First, Middle, Last): LOUIS VRANAS

18. Mother's Neme (First, Middle, Maiden Surneme): LULA WILLS

19a. Informent's Neme/Reletionship (Type, Print): MS. JENNIFER VRANAS (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 492 NORVELLE COURT, GLEN BURNIE, MD. 21061

20e. Method of Disposition: 1 Buriel 2 X Cremetion 3 Removel from State 4 Donetion 5 Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): CHESAPEAKE CREMATION CENTER, LLC.

Date: 2/17/2001

20c. Location - City or Town, Stete: STEVENSVILLE, MD.

21. Signature of Funeral Service Licensee: R. George Hopkins

22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediate Ceuse (Finel disease or condition resulting in deeth):

a. Acute Myocardial Infarction

Due to (or es e consequenca of):

b. Coronary Artery Disease

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Lest

Due to (or es e consequenca of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal Disease

Anemia.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Wes en eutopsy performed? 1 Yes 2 ☑ No

24b. Were eutopsy findings eveileble prior to completion of cause of death? 1 Yes 2 ☑ No

25. Wes case referred to medical examiner? 1 ☑ Yes 2 No

26. Piece of Deeth (Check only one): Hospitel: 1 Inpatient 2 ☑ ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Menner of Death: 1 ☑ Neturel 2 Accident 3 Suicide 4 Homicide 5 Pending investigetion 6 Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the cause(s) end menner es steted. 2 **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date and pleca, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Asha Vali M.D

29c. License number: D0052861

29d. Date signed (Month, Dey, Year): 2/13/01

30. Neme end address of person who completed cause of death (Item 23e) (Type, Print): ASHA VALI GLEN BURNIE HEALTH CENTER, BELTWAY CROSSING, 6320 RITCHIE HIGHWAY GLEN BURNIE MD 21061

State Registrar

31. Dete filed (Month, Dey, Year): FEB 15 2001

32. Registrer's Signature: Donna S Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

VRANAS, George

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM#1 per phys G792 022301 SS

Certificate of Death

Reg. No. 2001 04375

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VAN ERVIN WATSON, SR. ~~Van Ervin Watson, Jr.~~
2. Data of Death Month Day Yaar: Feb. 11, 2001
3. Tima of Death: 8:20 AM
4a. Facility Nama (If not institution, giva street and number): 8363 Bodkin Ave.
4b. City, Town, or Location of Death: Pasadena
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 425-64-2182
6. Sax: XX M 2☐ F
7. Aga (In yrs. last birthday): 63 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Yaar): May 6, 1937
9. Birthplaca (Stata or Foreign Country): MI

Usual Rasidance of Decedent

10a. Stata: MD
10b. County: Anne Arundel
10c. City, Town or Location: Pasadena
10d. Insida City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 8363 Bodkin Ave.
10f. Zip Code: 21122
10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Navar Married XX Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? XX Yas 2☐ No — If Yes, Giva Year or Datas: 1953-1956
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.): 1☐ Yas 2☒ No Specify:
14. Race - American Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highast grada compliated): Elamantary/Secondary (0-12): 12 — Collega (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): Electrician
16b. Kind of Business/Industry: Commercial Kitchen Equipment

17. Fathar's Nama (First, Middla, Last): John Elmer Watson
18. Mothar's Nama (First, Middla, Maidan Sumama): Rose Bedwell

19a. Informant's Name/Ralationship (Type, Print): Josephine G. Watson, Wife
19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 8363 Bodkin Ave. Pasadena MD. 21122

20a. Mathod of Disposition: 1☐ Burial 2XX Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other (Specify)
20b. Placa of Disposition (Nama of cematary, cramatory or othar placa): Metro Crematory
Data: 2-14-01
20c. Location - City or Town, Stata: Catonsville, MD

21. Signature of Funaral Sarvica Licensee: Robert Robinson
22. Nama and Addrass of Facility: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227

Physician /Medical Examiner

23a. Part I. Enter the disaasa, or complications that caused tha death. Do not antar tha mode of dying, such as cardiac or respiratory arrast, shock, or haart failura. List only ona cause on each line. — Approximata Interval Between Onsat and Daath

Immadiata Causa (Final disaasa or condition rasulting in death): a. Metastatic Pancreatic Cancer — 4 weeks
Dua to (or as a consequence of):
Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Diseasa or injury that initiated events rasulting in daath) Last:
b. Dua to (or as a consequance of):
c. Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Wara autopsy findings available prior to completion of causa of daath? 1☐ Yas 2☒ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No
26. Place of Death (Check only ona): Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Othar: 4☐ Nursing Homa 5☒ Rasidanca 6☐ Othar (Specify)
27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding Invastigation 6☐ Could not be datarmined
28a. Data of Injury (Month, Day Yaar)
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury ocurrad
28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)
28f. Location (Straat and Number or Rural Routa Number, City or Town, State)

29a. Cartifiar (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledga, death occurred at the time, date and placa, and due to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date and placa, and due to the cause(s) and mannar stated.
29b. Signatura and titla of cartifiar: Janet Cooper MD
29c. Licansa number: D46118
29d. Data signed (Month, Day, Yaar): Feb 12, 2001
30. Nama and addrass of person who completed causa of daath (Itam 23a) (Type, Print): JANET COOPER MD 1447 York Rd Lutherville MD 21093

State Registrar

31. Data filad (Month, Day, Yaar): FEB 15 2001
32. Registrar's Signatura: B. Sparks

DHMH 16 Rav 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Van Watson, SR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04376

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Michelle Ann Wiegand

2. Date of Death: Month February Dey 12 Yeer 2001

3. Time of Death: 2:45 A.M.

4a. Facility Name (If not institution, give street end number): Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-54-2968

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthdey): 38 Yrs.

If Under 1 Yaar: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Day, Year): 5/3/1962

9. Birthplace (State or Foreign Country): Baltimore, MD

Usual Residence of Decedent

10a. Stete: MD

10b. County: Baltimore

10c. City, Town or Location: Kingsville

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 7800 Chapman Road

10f. Zip Code: 21087

10g. Citizen of Whet Country?: USA

11. Maritel Stetus: 1☐ Never Merried 2☐ Married 3☐ Widowed 4☒ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☐ No Specify: X

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 12 years; College (1-4or 5+): N/A

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Manager

16b. Kind of Business/Industry: G.N.C. Store

17. Fether's Neme (First, Middle, Last): Benjamin Wiegand

18. Mother's Neme (First, Middle, Maiden Surname): Carol Jean Allender

19a. Informent's Neme/Reletionship (Type, Print): Benjamin Wiegand (father)

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 7800 Chapman Rd. Kingsville, Md 21087

20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other place): Metro Crematory

Dete: 2/15/2001

20c. Location - City or Town, State: Baltimore, MD

21. Signeture of Funerel Service Licensee: ▶ Heather Lassahn Chomack

22. Nems and Addrass of Fecility: E.F.Lassahn Funeral Home 11750 Belair Rd. Kingsville, Md 21087

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet beceme the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediete Causa (Final diseese or condition resulting in deeth)

e. Sepsis — 2 days

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Lest

b. Cholecystitis — 5 days

Due to (or es e consequence of):

c.

Due to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Plece of Deeth (Check only one): Hospitel: 1☑ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Menner of Deeth: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end place, end dua to the cause(s) end mannar es steted. 2☐ **Medicat Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner steted.

29b. Signeture end title of certifier: ▶ Stuart R. Willes, MD

29c. License number: D36663

29d. Date signed (Month, Dey, Year): February 12, 2001

30. Neme end address of person who completed causa of deeth (Item 23a) (Type, Print): Dr. Stuart Willes 9000 Franklin Square Dr. Baltimore Maryland 21237

State Registrar

31. Dete filed (Month, Dey, Year): FEB 13 2001

32. Registrer's Signeture: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Wiegand, Michelle Ann
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04377

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Willie Mae Watson
2. Date of Death (Month, Day, Year): February 8, 2001
3. Time of Death: 6:30 AM
4a. Facility Name *(If not institution, give street and number)*: Greater Balto. Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 242-24-5675
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 6, 1923
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1600 W. Mt. Royal Ave Apt. 506
10f. Zip Code: 21217
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Printed Circuit
16b. Kind of Business/Industry: Westinghouse

17. Father's Name *(First, Middle, Last)*: Joseph Parker
18. Mother's Name *(First, Middle, Maiden Surname)*: Nannie Hawkins

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Naomi Wooley (daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3910 Sadie Rd. Randallstown, Md. 21133

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Woodlawn Cemetery | Date: 2/13/2001
20c. Location - City or Town, State: Balto. Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Pneumonia

Due to (or as a consequence of):
b. Ischemic Heart Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. NIDDM

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D0047762
29d. Date signed *(Month, Day, Year)*: 2/9/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nick Mellis 7801 York Rd. #224 Towson, MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 15 2001
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Willie Mae Watson
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04378

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Larry Wilson

2. Date of Death (Month, Day, Year): February 13 2001

3. Time of Death: 6:35 Am

4a. Facility Name (If not institution, give street and number): NORTH WEST MEDICAL CENTER

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTO. CO.

Funeral Director

5. Social Security Number: 245-72-4827

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 54 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): OCT. 20, 1946

9. Birthplace (State or Foreign Country): N.C.

Usual Residence of Decedent

10a. State: MD

10b. County: BALTO. CO.

10c. City, Town or Location: RANDALLSTOWN

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 12 COACHMEN CT. APT. G2

10f. Zip Code: 21133

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FEDERAL EMPLOYEE

16b. Kind of Business/Industry: U.S. POSTAL SERVICE

17. Father's Name (First, Middle, Last): CLAUDE WILSON

18. Mother's Name (First, Middle, Maiden Surname): SOPHIA RITTER

19a. Informant's Name/Relationship (Type, Print): JORDAN K WILSON SR.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 42 CENTERWOOD STREET NORTH BABYLON, N.Y.

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY

Date: 2-17-2001

20c. Location - City or Town, State: CATONSVILLE MD

21. Signature of Funeral Service Licensee: E.N.WALKER JR

22. Name and Address of Facility: ESTEP BROS FUNERAL SERV.PA 1300 EUTAW PLACE BALTIMORE MD 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode ot dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)

a. Tension pneumothorax

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Ruptured pneumatic lobes spontaneously

Due to (or as a consequence of):

c. End stage emphysema

Due to (or as a consequence of):

d. Pneumonia

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and piece, and due to the ceuse(s) and menner es stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Alice Hsieh

29c. License number: H43974

29d. Date signed (Month, Day, Year): February 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alice Hsieh Northwest Hospital Randallstown, MD

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001

32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04379

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Victoria Teresa Wielech
2. Dete of Deeth Month / Dey / Yeer: February 12, 2001
3. Time of Deeth: 9:15 P.M.
4e. Facility Neme *(If not institution, give street end number)*: 4001 Greenway
4b. City, Town, or Locelion of Deeth: Baltimore
4c. County of Deeth: N/A

Funeral Director

5. Sociel Security Number: 213-34-9427
6. Sex: 1☐ M 2☑ F
7. Age *(In yrs. lest birthdey)*: 66 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: 11/28/1934
9. Birthpiece *(Stete or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street end Number: 4001 Greenway
10f. Zip Code: 21218
10g. Citizen of Whet Country?: U.S.A.

11. Meritel Stetus: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces?: 1☐ Yes 2☑ No — If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☑ No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12th — College (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Domestic

17. Fether's Neme *(First, Middle, Last)*: Victor Grzymala
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Katarzyna Wegrzyniak

19e. Informent's Neme/Reletionship *(Type, Print)*: Dennis Wielech / Husband
19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 4001 Greenway Baltimore, Maryland 21218

20e. Method of Disposition: 1☑ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Holy Rosary Cemetery — Dete: 2/15/01
20c. Locelion - City or Town, State: Baltimore, Maryland

21. Signeture of Funerel Service Licensee: David J. Weber
22. Neme and Address of Feciility: David J. Weber Funeral Homes, P.A. 401 S. Chester Street Baltimore, Maryland 21231

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line. — Approximete Intervel Between Onset end Death

Immediele Ceuse (Finel diseese or condition resulting in deeth)
e. Probele acute myocardial infarction
Due to (or es e consequence of)
b. Hypertension
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest
Due to (or es e consequence of):
c. Rheumatoid Arthritis
Due to (or es e consequence of):
d. Sjogrens Syndrome

Pert II. **Other significent conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.

23b. Did tobecco use contribute to the cause of death?: 1☐ Yes 2☐ No 3☐ Probebly 4☑ Unknown

24e. Wes en eutopsy performed?: 1☐ Yes 2☑ No
24b. Were autopsy findings eveilable prior to completion of ceuse of deeth?: 1☐ Yes 2☐ No

25. Wes cese referred to medical examiner?: 1☐ Yes 2☑ No
26. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invesligeiion 6☐ Could not be determined
28e. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury
28c. Injury et Work?: 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - Ai home, farm, sireei, faciory, office building, etc. *(Specify)*
28f. Locelion *(Street end Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to ihe ceuse(s) end menner stated.
29b. Signeture and title of certifier: Gary B. Ruppert
29c. License number: D18446
29d. Dele signed *(Month, Dey, Yeer)*: Feb. 13, 2001
30. Neme and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): 301 Saint Paul Place #411, Baltimore MD 21202

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: FEB 15 2001
32. Registrer's Signeture: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04380

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Eugene Ash
2. Date of Death (Month, Day, Year): Feb 01, 2001
3. Time of Death: 1724
4a. Facility Name (If not institution, give street and number): Union Hospital
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 222-16-2884
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 1, 1929
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: CECIL
10c. City, Town or Location: ELK MILLS
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 508 ELK MILLS RD
10f. Zip Code: 21920
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: KOREA 1952
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): —
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SECURITY GUARD
16b. Kind of Business/Industry: UNIVERSITY OF DELAWARE

17. Father's Name (First, Middle, Last): LEONARD L. ASH
18. Mother's Name (First, Middle, Maiden Surname): GLADYS RUTH

19a. Informant's Name/Relationship (Type, Print): JANICE A. POTTS SISTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 197 APPLETON RD. ELKTON, MD 21921

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CHERRY HILL METH. CEM. | Date: 2/6/01
20c. Location - City or Town, State: CHERRY HILL, MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: GEE FUNERAL HOME 259 E. MAIN ST. ELKTON, MD 2192(

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
e. MYOCARDIAL INFARCTION

Due to (or as a consequence of):
CARDIOMYOPATHY

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. [ ]
Due to (or as a consequence of):
c. ATRIAL FIBRILLATION
Due to (or as a consequence of):
d. AORTIC STENOSIS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CORONARY ARTERY DISEASE
CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D0012864
29d. Date signed (Month, Day, Year): FEBRUARY 1, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): LEO A. NASERA, MD 111 W. HIGH ST. ELKTON, MD. 21921

State Registrar

31. Date filed (Month, Day, Year): 2-2-01 FEB 02 2001
32. Registrar's Signature: [signature]

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

RW

15 + IVA

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04381

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Beulah Frances Ashby
2. Date of Death Month / Day / Year: February 4 2001
3. Time of Death: 0340 A
4a. Facility Name *(If not institution, give street and number)*: SunBridge Care For Elkton
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 222-16-2928
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 86 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Year)*: May 17, 1914
9. Birthplace *(Stete or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Elkton
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 999 Oldfield Point Road
10f. Zip Code: 21921
10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Food Service/Cafeteria
16b. Kind of Business/Industry: Board of Education

17. Father's Name *(First, Middle, Last)*: George S. Hopkins
18. Mother's Name *(First, Middle, Maiden Surneme)*: Rachel Whisner

19a. Informant's Neme/Reletionship *(Type, Print)*: Shirley F. Murray/Daughter
19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 999 Oldfield Point Road, Elkton, Maryland 21921

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Gracelawn Memorial Park
Date: 2/7/01
20c. Location - City or Town, State: New Castle, Delaware

21. Signature of Funeral Servica Licensee: ▶ Donald S. Hicks
22. Name and Address of Facility: Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Finel disease or condition resulting in deeth): e. Transient Ischemic Attack

Due to (or as a consequenca of): b. Cerebrovascular Accident

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disesse or Injury that initiated events resulting in death) Last

Due to (or as a consequence of): c. Hyperglycemia

Due to (or as a consequenca of): d. Depression

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD
29c. License number: D56820
29d. Date signed *(Month, Dey, Year)*: February 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOSIER NISNISAN MD 223 W MAIN ST. ELKTON MD 21921

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 06 2001
32. Registrar's Signeture: ▶ Bonnie B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04382

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Valera Alice Arnold
2. Data of Death — Month: February Day: 3 Yaer: 2001
3. Time of Deeth: 0839
4a. Facility Nema (If not Institution, give street and number): Union Hospital
4b. City, Town, or Location of Deeth: Elkton
4c. County of Deeth: Cecil

Funeral Director

5. Social Security Number: 181-01-8296
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Year): DEC 6, 1914
9. Birthplece (Stete or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: Harford
10c. City, Town or Location: Edgewood
10d. Insida City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1307 D Clover Valley Way
10f. Zip Code: 21040
10g. Citizen of What Country?: United States

11. Meritel Stetus: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent'e Education (Specify only highast grada completed): Elementery/Secondery (0-12): 11 — Collega (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress
16b. Kind of Business/Industry: Garment Manufacturing

17. Fether's Neme (First, Middle, Last): Elmer E. Fairchild
18. Mother's Name (First, Middle, Maiden Surname): Alice M. Hawk

19a. Informent's Neme/Reletionship (Type, Print): Alfred Francis Arnold/Son
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 30 Silchester Court, Elkton, Maryland 21921

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other place): Garden of Faith Memorial Gardens
Dete: 2/7/01
20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Donald S. Hicks
22. Name end Address of Fecility: Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart feilure. List only one cause on eech line.

Approximete Intervel Between Onset end Death

Immediete Cause (Finel diseese or condition resulting in deeth)
a. Acute Myocardial Infarction — Days
Due to (or es e consequence of):
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Last
b. Coronary Artery Disease — years
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other eignificant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uee contribute to the cauee of death? 1☐ Yee 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☑ No
24b. Were eutopsy findings availabla prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examinar? 1☐ Yes 2☑ No
26. Placa of Deeth (Check only one): Hospitel: 1☑ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Rasidence 6☐ Other (Specify)

27. Menner of Death: 1☑ Netural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Phyeician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On tha basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) and menner steted.

29b. Signetura end title of certifier: ▶ S. Sachdev M.D.
29c. Licansa number: D23322
29d. Date signed (Month, Day, Year): 2/5/2001

30. Neme and eddrase of person who completed causa of death (Item 23e) (Type, Print): S. Sachdev MD. 118 North St Suite 3B, Elkton MD 21921

State Registrar

31. Deta filed (Month, Day, Year): FEB 0 0 2001
32. Registrar's Signeture: ▶ D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04383

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Leon T. Ashcraft, Jr.
2. Date of Death: Month FEB, Day 4, Year 2001
3. Time of Death: 8:40 PM
4a. Facility Name (If not institution, give street and number): 168 Landside Lane
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 222-18-0423
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 69 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr 8, 1931
9. Birthplace (State or Foreign Country): Delaware

Usual Residence of Decedent

10a. State: MD
10b. County: Cecil
10c. City, Town or Location: Elkton
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 168 Landside Lane
10f. Zip Code: 21921
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Lab Technician
16b. Kind of Business/Industry: Chemical Manufacturing

17. Father's Name (First, Middle, Last): Leon T. Ashcraft, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Eleanor Stewart

19a. Informant's Name/Relationship (Type, Print): Reba Mae Ashcraft - wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 168 Landside Lane, Elkton, MD 21921

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): All Saints Cemetery
Date: 2/8/01
20c. Location - City or Town, State: Wilmington, DE.

21. Signature of Funeral Service Licensee: Frank C. Mayer, Jr.
Frank C. Mayer, Jr.
22. Name and Address of Facility: Spicer-Mullikin Funeral Homes, Inc. 1000 N. DuPont Pkwy., New Castle, DE 19720

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Small Cell Cancer of the Lung
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: C1000964
29d. Date signed (Month, Day, Year): 2/6/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Timothy Wozniak, MD -4745 Ogletown-Stanton Rd., Newark, DE 19713

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

V.D

10

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04384

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Howard Robert Austin
2. Date of Death (Month, Day, Year): January 25, 2001
3. Time of Death: 12:05am
4a. Facility Name (If not institution, give street and number): 6909 Tennyson Terrace
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 346-14-7728
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar. 30, 1925
9. Birthplace (State or Foreign Country): Illinois

Usual Residence of Decedent

10a. State: Md.
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6909 Tennyson Terrace
10f. Zip Code: 20855
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electronics Engineer
16b. Kind of Business/Industry: Electronics

17. Father's Name (First, Middle, Last): Howard B. Austin
18. Mother's Name (First, Middle, Maiden Surname): Violet M. Arthur

19a. Informant's Name/Relationship (Type, Print): Patricia Austin (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6909 Tennyson Terrace Rockville, Md. 20855

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Memorial Park
Date: Jan. 30, 2001
20c. Location - City or Town, State: Rockville, Md.

21. Signature of Funeral Service Licensee: Curtis E. Day
22. Name and Address of Facility: DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, Md. 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Respiratory Failure
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Aspiration pneumonia
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Cerebral Vascular Accident; Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D0056219
29d. Date signed (Month, Day, Year): 1/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Katarzyna Ostrzenska M.D. 11906 Darnestown Rd. North Potomac, Md. 20878

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001
32. Registrar's Signature: Lenora B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04385

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Eloise M. Anderson
2. Dete of Death Month Dey Yeer: Janaury 31, 2001
3. Time of Death: 6:00am
4e Fecility Neme *(If not institution, give street and number)*: Wilson Health Care Center
4b. City, Town, or Location of Deeth: Gaithersburg
4c. County of Deeth: Montgomery

Funeral Director

5. Sociel Security Number: 216-46-9346
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 102 Yrs. — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: Mar. 29, 1898
9. Birthplece *(Stete or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 403 Russell Avenue Apt. G-4
10f. Zip Code: 20877
10g. Citizen of Whet Country?: United States

11. Meritel Status: 1☐ Never Married 2☐ Merried 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12) / College (1-4or 5+): 2
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher
16b. Kind of Business/Industry: Education

17. Fether's Neme *(First, Middle, Last)*: Samuel V. Mace
18. Mother's Name *(First, Middle, Maiden Sumame)*: Clara V. Marsh

19a. Informent's Neme/Relationship *(Type, Print)*: John W. Debelius, III — Personal Repres.
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 320 East Diamond Avenue, Gaithersburg, MD 20877

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removet from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Druid Ridge Cemetery
Dete: 2/2/01
20c. Location - City or Town, State: Pikesville, Maryland

21. Signature of Funeral Service Licensee: Robert A. DeVol
22. Name and Address of Feclity: DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877

Physician /Medical Examiner

23e. Part I. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one cause on each line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Final disease or condition resulting in death)
a. Congestive Heart Failure — 2 Days

Due to (or es e consequence of):
b. Coronary Artery Disease

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Last
Due to (or as e consequence of):
c.

Due to (or as e consequence of):
d.

Part II. **Other stgnlftcant condltfons** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner es stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) end manner steted.

29b. Signeture end title of certifier: H. Robert Birschbach M.D.
29c. License number: D04115
29d. Date signed *(Month, Dey, Yeer)*: January 31, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): H. Robert Birschbach, M.D. 6320 Democracy Blvd., Bethesda, MD 20817

State Registrar

31. Dete filed *(Month, Day, Year)*: FEB 02 2001
32. Registrer's Signeture: Laura B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

6

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

20

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04386

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lorraine Creech Brown
2. Date of Death (Month, Day, Year): January 27, 2001
3. Time of Death: 8:15 AM.

4a. Facility Name (If not institution, give street and number): 2201 Colston Drive
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 239-20-7607
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr. 25, 1915
9. Birthplace (State or Foreign Country): Louisiana

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 2201 Colston Drive
10f. Zip Code: 20910
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Housewife

17. Father's Name (First, Middle, Last): Nicholas Humphrey
18. Mother's Name (First, Middle, Meiden Surneme): Josephine (Unknown)

19a. Informant's Name/Relationship (Type, Print): Lawrence Creech - Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8495 Van Wie Dr. West; Baldwinsville, NY. 13027

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Rock Creek Cemetery | Dete: 1/31/01
20c. Location - City or Town, State: Washington, DC.

21. Signature of Funeral Service Licensee: W. Gawler Mauzy
22. Name and Address of Facility: Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. NW., Washington, D.C. 20016

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximete Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. Breast Cancer	6 Months
	Due to (or as e consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Atherosclerotic Cardiovascular Disease

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, dete end place, and due to the ceuse(s) and menner steted.

29b. Signature and title of certifier: Michael J Grady
29c. License number: D0038781
29d. Date signed (Month, Day, Year): February 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael J. Grady, MD. 4910 Massachusetts Ave. NW. #210, Washington, D.C. 20016

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signature: Laura B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04387

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: IMOGENE M. BROOKS
2. Date of Death (Month, Day, Year): January 29, 2001
3. Time of Death: 11:15 AM
4a. Facility Name *(If not institution, give street and number)*: 3406 Lancer Drive
4b. City, Town, or Location of Death: Hyattsville
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 514-16-5139
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 76 Yrs. — If Under 1 Yaar: Months / Days — If Undar 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Aug. 15, 1924
9. Birthplaca *(State or Foreign Country)*: Iowa

Usual Residence of Decedent

10a. Stata: N/A
10b. County: N/A
10c. City, Town or Location: Washington, D.C.
10d. Inside City Limits: 1☒ Yas 2☐ No
10e. Street and Number: 238 Tuckerman Street, N.W.
10f. Zip Coda: 20011
10g. Citizan of What Country?: United States

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*
14. Race - Amarican Indian, Black, Whita, atc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work dona during most of working life. DO NOT use retired)*: National Education Association Writer
16b. Kind of Businass/Industry: Administration

17. Father's Nama *(First, Middla, Last)*: Julius C. McGinty
18. Mothar's Nama *(First, Middle, Maiden Sumama)*: Alberta Smith

19a. Informant's Name/Ralationship *(Type, Print)*: Albert W. Lofton Son
19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, State, Zip Code)*: 800 4th Street, S.W.,[125] Washington, D.C. 20024

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*
20b. Ptace of Disposition *(Name of cematary, crematory or othar place)*: Ft. Lincoln Cemetery
Data: 2/2/01
20c. Location - City or Town, Stata: Brentwood, Maryland

21. Signature of Funaral Service Licensee: Thomas G. Clyburn
22. Nama and Addrass of Facility: McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. 20012

Physician /Medical Examiner

23a. Part1. Enter tha diseasa, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on eech line. — Approximate Interval Between Onset and Death

Immediata Causa (Final disaasa or condition rasulting in death)
a. Lung Cancer
Dua to (or as a consequence of):
Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last
b.
Dua to (or as a consequence of):
c.
Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the causa of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Ware autopsy findings available prior to completion of causa of death? 1☐ Yas 2☐ No

25. Was casa referred to medicat axaminar? 1☐ Yas 2☒ No

26. Placa of Death *(Check only ona)*
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Othar: 4☐ Nursing Homa 5☐ Residanca 6☒ Othar *(Specify)* daughters home

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be datarmined
28a. Data of Injury *(Month, Day Yaar)*
26b. Time of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To tha best of my knowledge, death occurred at tha time, date and place, and dua to the causa(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to tha cause(s) and mannar stated.

29b. Signatura and titla of certifier
29c. Licansa number: D41119
29d. Data signed *(Month, Day, Year)*: January 30, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Daya Sharma, M.D. 50 West Edmonston Drive #303, Rockville, MD 20852

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 31 2001
32. Registrar's Signatura: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04388

Geneva Victoria Branson

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Geneva Victoria Branson
2. Date of Death: Month: January Day: 26 Year: 2001
3. Time of Death: 2:15 pm
4a. Facility Name (If not institution, give street and number): Doctors Community Hospital
4b. City, Town, or Location of Death: Lanham
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 434-12-9019
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 18, 1915
9. Birthplace (State or Foreign Country): Pascagoula, MS

Usual Residence of Decedent

10a. State: N/A
10b. County: N/A
10c. City, Town or Location: Washington, D.C.
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 324 Ogelthorpe Street, N.E.
10f. Zip Code: 20011
10g. Citizen of What Country?: United States
11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): ; College (1-4or 5+): 2
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Child Care Specialist
16b. Kind of Business/Industry: Private
17. Father's Name (First, Middle, Last): John Thomas Beaudreau
18. Mother's Name (First, Middle, Meiden Surneme): Eulalie Glaude
19a. Informent's Neme/Reletionship (Type, Print): Yvette H. Birdsong Niece
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 324 Ogelthorpe Street, N.E., Washington, D.C. 20011
20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Plece of Disposition (Neme of cemetery, cremetory or other piece): Arlington National
Dete: 2/2/01
20c. Location - City or Town, Stete: Arlington, VA
21. Signeture of Funerel Service Licensee: Andre Thompson
22. Neme end Address of Fecility: McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. 20012

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

b

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert failure. List only one ceuse on each line.

Approximete Interval Between Onset end Death

Immediete Ceuse (Finel disease or condition resulting in deeth)
e. Anemia — 4 years

Due to (or es e consequence of):
b. Chronic gastrointestinal bleeding

Sequentially list conditions, if any, leeding to immediete ceuse. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in death) Last

Due to (or es e consequence of):
c. Factor VIII inhibitor

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
Renal Cell Cancer, Sepsis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings available prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medicel examiner? 1☐ Yes 2☑ No

26. Place of Deeth (Check only one): Hospitel: 1☑ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The lew requires that the deeth certificate be executed within 24 hours efter death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the buriel-transit

6

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end manner stated.
29b. Signeture end title of certifier: Dan H. Yablonowitz MD
29c. License number: D20079
29d. Dete signed (Month, Dey, Yeer): 1/27/01
30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): Dan H. Yablonowitz MD 7404 Executive Pl., Lanham MD 20706

State Registrar

31. Dete filed (Month, Day, Year): JAN 31 2001
32. Registrer's Signeture: Brenda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 04389

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death (Month, Day, Year)	3. Time of Death
MOHAMED	BOUH	Feb. 1, 2001	2:20am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
WASHINGTON ADVENTIST HOSPITAL	Takoma Park	Prince George

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	If Under 1 Year: Days	If Under 24 Hrs.: Hours	If Under 24 Hrs.: Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
306-23-7457	1☒ M 2☐ F	37 Yrs.					Dec. 12-63	Mauritania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince Geo.	Hyattsville	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2614 Kerkwood Pl. #203	26718	Mauritania

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Parking Attendant	Parking

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Mohamed Dou	Fatimou Khaled

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Helmane Bouck-Brother	540 N. Thomas St.#3,Arlington,Va. 22203

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Famliy Cemetery	2-5-2001	Nouakchott Mauritania

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Paul Le Matre	Universal II Mortuary Inc. 411 Kennedy St,N.W.,Washington,D.C.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only one* cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Atherosclerotic cardiovascular disease	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Patricia L. Tomsko, MD	D51916	Feb. 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Patricia L. Tomsko, MD 11140 Rockville Pike, PMB 348, Rockville, MD 20852

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 02 2001	Donna G. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

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ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEMS# 10a,b,c,e,& f per inf G793 030601 SC

Certificate of Death

Reg. No. 2001 04390

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Casmira R. Bobowski	January 29, 2001	2:15 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Wilson Health Care Center	Gaithersburg	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
362-12-8571	1☐ M 2☒ F	83 Yrs.			March 4, 1917	Ohio

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MI ~~Maryland~~	Macomb ~~Montgomery~~	Centerline ~~Montgomery Village~~	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8377 Busch ~~24015 Meadow Pond Place~~	48015 ~~20886~~	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Stanley Zdrodowski	Adela Raciborski

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Edward F. Bobowski/ Son	47 Baldwin Street Bloomfield, New Jersey 07003

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Montgomery Crematorium Inc.	February 1, 2001	Bethesda, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature] M00335	Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cancer of Oral Cavity	mnth
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	D20516	January 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joel R. Schulman, M.D. 9410 Old Georgetown Road Bethesda, Maryland 20814

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 01 2001	Geneva G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

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ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04391

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Leonard Courtney Bluebond
2. Date of Death (Month, Day, Year): January 25, 2001
3. Time of Death: 11:05 AM
4a. Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 179-03-0876
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Apr. 1, 1918
9. Birthplace *(State or Foraign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Insida City Limits: 1☒ Yas 2☐ No
10e. Street and Number: 9701 Fields Rd., Apt. 802
10f. Zip Code: 20878
10g. Citizen of Whaf Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☒ Yas 2☐ No If Yes, Giva Year or Datas: Unk.
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*
14. Race - Amarican Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Photometrist
16b. Kind of Businass/Industry: National Bureau of Standards

17. Father's Nama *(First, Middle, Last)*: Jules Bluebond
18. Mothar's Nama *(First, Middle, Maiden Surname)*: Martha Rossin

19a. Informant's Name/Ralationship *(Type, Print)*: Doris M. Bluebond/ Wife
19b. Mailing Addrass *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9701 Fields Rd., Apt. 802, Gaithersburg, MD 20878

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Name of cematary, crematory or other place)*: Metropolitan Crematory — Data: Jan. 26, 2001
20c. Location - City or Town, Stata: Alexandria, VA

21. Signature of Funaral Sarvice Licensee: ▶ [signature]
22. Name and Address of Facility: Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, MD 20852

Physician /Medical Examiner

23a. Part1. Entar tha disaase, or complications that caused tha daath. Do not entar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only ona cause on aach lina. — Approximata Intarval Batwaen Onsat and Daath

Immediata Causa (Final diseasa or condition rasulting in death):
a. Pulmonary Embolism — 3 hours
Due to (or as a consequence of):
b. Pneumococcal Meningitis — 1 week
Dua to (or as a consequence of):
c. Pneumococcal Septicemia — 1 week
Dua to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.: Hypertension, Coronary Artery Disease

23b. Did **tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to complation of causa of daath? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical examinar? 1☐ Yes 2☒ No

26. Placa of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Othar: 4☐ Nursing Homa 5☐ Rasidence 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At homa, farm, street, factory, offica building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledga, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar stated.

29b. Signature and title of certifier: ▶ Carl I. Schoenberger MD
29c. License number: D26540
29d. Data signed *(Month, Day, Year)*: January 25, 2001

30. Name and eddrass of parson who completed causa of death (Item 23a) (Type, Print): Carl I. Schoenberger, 16220 Frederick Rd., Gaithersburg, MD

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 31 2001
32. Registrar's Signatura: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

b

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04392

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret D. Binkley
2. Date of Death (Month, Day, Year): January 31, 2001
3. Time of Death: 9:00 PM
4a. Facility Name (If not institution, give street and number): Manor Care Fernwood
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 575-16-0796
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 24, 1914
9. Birthplace (State or Foreign Country): Arizona

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Chevy Chase
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4630 Norwood Drive
10f. Zip Code: 20815
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): - | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Petroleum Engineer
16b. Kind of Business/Industry: Internal Revenue Service

17. Father's Name (First, Middle, Last): Douglas Delano
18. Mothar's Nama (First, Middle, Maiden Sumame): Gladys Arnold

19a. Informent's Neme/Relationship (Type, Print): Phillip D. Pack/ Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4630 Norwood Drive, Chevy Chase, Maryland 20815

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc.
Date: February 2, 2001
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature] M00689
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, heert failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. CARDIAC ARREST

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b. INTRACEREBRAL BLEED

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Dfd tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Ware autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was cese referred to medicet examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be detarmined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifiar (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and menner es stated. 2☐ **Medicet Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end piece, and due to the ceuse(s) and manner stated.

29b. Signatura and title of certifier: ▶ Attankasid, M.D., Ph.D.
29c. License number: D55054
29d. Date signed (Month, Day, Year): JANUARY 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ATTAN KASID 17519 REDLAND ROAD ROCKVILLE

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signature: [signature] D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04393

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth Eleanor Bender
2. Date of Death: Month January Day 25, Year 2001
3. Time of Death: 2:00 PM
4a Facility Name (If not institution, give street and number): Wilson Health Care Center
4b. City, Town, or Location of Death:
4c. County of Death:

Funeral Director

5. Social Security Number: 137-24-3895
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 71 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 8, 1929
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 9124 Edgewood Drive
10f. Zip Code: 20877
10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 3; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Ralph MacLean
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Barry

19a. Informant's Name/Relationship (Type, Print): Stanley Bender, husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9124 Edgewood Drive, Gaithersburg, MD 20877

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery
Date: Jan 30, 2001
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: Gary M. Fussi
22. Name and Address of Facility: DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Picks Disease — Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Steven Dolinsky
29c. License number: D20148
29d. Date signed (Month, Day, Year): January 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Steven Dolinsky, M.D., 911 Russell Avenue Gaithersburg, MD 20877

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001
32. Registrar's Signature: Laura B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

7

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04394

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hameeda Begum

2. Date of Death: Month 01 Day 29 Year 01

3. Time of Death: 835A

4a. Facility Name (If not institution, give street and number): Prince George's Hospital

4b. City, Town, or Location of Death: Cheverly, MD.

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 214-59-1478

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 64 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 01-08-37

9. Birthplace (State or Foreign Country): PAKISTAN

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Geo.

10c. City, Town or Location: Suitland

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4704 Hudson Ave #C

10f. Zip Code: 20746

10g. Citizen of What Country? Pakistan

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Asian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Ghulam Mohammad

18. Mother's Name (First, Middle, Maiden Surname): Fathima BIBI

19a. Informant's Name/Relationship (Type, Print): Ghulam Raza-Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4704 Hudson Ave #C, Suitland, Md. 20746

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Family Cemetery

Date: 2-1-2001

20c. Location - City or Town, State: Lahore, Pakistan

21. Signature of Funeral Service Licensee: Jane de Mata

22. Name and Address of Facility: Universal II Mortuary Inc. 411 Kennedy St, N.W., Wash, D.C.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Myocardial infarction + Cardiogenic Shock

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Diabetes Mellitus

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d. Congestive Heart failure

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Allison R. Edwards MD

29c. License number: D32051

29d. Date signed (Month, Day, Year): 01/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Allison R. Edwards, MD 3001 Hospital Dr., Cheverly, Maryland 20785

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signature: Barbara B. Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural" or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04395

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Amelia A. Baker

2. Date of Death (Month, Day, Year): January 30, 2001

3. Time of Death: 12:10 AM

4a. Facility Name *(If not institution, give street and number)*: Doctor's Community Hospital

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 161-16-0140

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept.6,1912

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: College Park

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4927 Hollywood Road

10f. Zip Code: 20740

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use ratired)*: Homemaker

16b. Kind of Business/Industry: own home

17. Father's Name *(First, Middle, Last)*: Ernest O. Ulrich

18. Mother's Name *(First, Middle, Maiden Surname)*: Bertha Katherine Miller

19a. Informent's Name/Reletionship *(Type, Print)*: Janice L. Gann - Daughter

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: same as #10a - 10g

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, cremetory or other place)*: Fort Lincoln Cemetery | Data: 2/2/2001

20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: Donald V. Borgwardt

22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Death

Immediete Ceuse (Final diseese or condition resulting in death) a. Cerebro v a sicular accident — 10 days

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest

b.

Due to (or as e consequence of):

c.

Due to (or as e consequence of):

d.

Pert II. **Other signifi cant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.: Pneumonia, Diabetes mellitus

23b. Did tobacco uaa contributa to the causa of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was casa referred to medicel examinar? 1☐ Yes 2☑ No

26. Place of Deeth *(Chack only one)*: Hospitel: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Menner of Death: 1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)* 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner steted.

29b. Signature end title of certifier: D. Granite MD

29c. License number: D17572

29d. Date signed *(Month, Day, Year)*: 1/30/01

30. Neme and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): D. Granite, MD 115 Centerway Greenbelt, MD 20770

State Registrar

31. Dete filed *(Month, Dey, Year)*: FEB 01 2001

32. Registrer's Signature: Brenda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

Amelia Alverta BAKER

GF

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04396

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph E. Bailey

2. Date of Death (Month, Day, Year): JANUARY 27, 2001

3. Time of Death: 10 15 PM

4a Facility Name (If not institution, give street and number): Stella Maris at Mercy Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 215-74-9311

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 41 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb 15, 1959

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 280 Spring Court

10f. Zip Code: 21231

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Rece - Americen Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer

16b. Kind of Business/Industry: Environmental Services

17. Father's Neme (First, Middle, Last): Clarence Bailey

18. Mother's Name (First, Middle, Maiden Sumame): Mary Elizabeth Allen

19a. Informent's Name/Relationship (Type, Print): Ella Clark /Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3722 Raspe Avenue, Baltimore, MD 21206

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removei from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other place): Voshell's Memorial

Date: Jan 30 2001

20c. Location - City or Town, State: Dundalk, MD

21. Signature of Funeral Service Licensee: [signature] M00986

22. Name and Address of Facility: Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert failure. List only one ceuse on eech iine.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death): a. Acquired Immuno deficiency Syndrome

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings eveileble prior to completion of ceuse ot death? 1 ☐ Yes 2 ☐ No

25. Was cese referred to medicel examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): STELLA MARIS at MERCY Hospice

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Menner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es steted. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) end manner steted.

29b. Signature end title of certifier: [signature] MD

29c. License number: D40854

29d. Date signed (Month, Day, Year): JANUARY 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG 301 St Paul Pl BALTIMORE Md 21202

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001

32. Registrar's Signeture: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04397

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sophie Jewel Bishop

2. Date of Death: Month: January Day: 30 Year: 2001

3. Time of Death: 0400

4a. Facility Name (If not institution, give street and number): Union Hospital

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 218-26-8470

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 1, 1932

9. Birthplace (State or Foreign Country): Kentucky

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Colora

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2679 Jacob Tome Hwy.

10f. Zip Code: 21917

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Milton Slone

18. Mother's Name (First, Middle, Maiden Surname): Esta Akers

19a. Informant's Name/Relationship (Type, Print): Andrew Bishop/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2679 Jacob Tome Hwy., Colora, MD 21917

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): R. A. Ferris & Co., Inc. Date: 2-2-01

20c. Location - City or Town, State: West Chester, PA

21. Signature of Funeral Service Licensee: Richard L. Goodie

22. Name and Address of Facility: R. T. Foard Funeral Home, P. A. 111 S. Queen St., Rising Sun, MD 21911

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — 2 days

Due to (or as a consequence of):
b. Diabetes Mellitus

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. wrinkle fracture infection

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Jui Chih Han MD

29c. License number: D048823

29d. Date signed (Month, Day, Year): Jan. 30 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JUI CHIH HSU, MD 223 West Main St-Elkton MD 21921

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001

32. Registrar's Signature: ▶ Emma B. Sparks

ORIGINAL

DHMH 16 Rev 6/95

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04398

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy D. Boesel

2. Date of Death: Month Jan. Day 30, Year 2001

3. Time of Death: 8:00 pm

4e. Facility Name (If not institution, give street and number): Riva Terrace Assisted Living

4b. City, Town, or Location of Death: Riva

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 275-42-1997

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Mar. 12, 1911

9. Birthplace (State or Foreign Country): USA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Riva

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3073 Riverview Road

10f. Zip Code: 21140

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 4

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Robert Delscamp

18. Mother's Name (First, Middle, Maiden Surname): Florence Weifenbach

19a. Informant's Name/Relationship (Type, Print): David Boesel/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 200 Severn River Road, Severna Park, MD 21146

20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Greenlawn Cemetery

Dete: Feb.10 2001

20c. Location - City or Town, Stete: Wapakoneta, OH

21. Signature of Funeral Service Licensee: John C Barranco

22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth) e. Parkinsons — 3years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

b. Due to (or as a consequenca of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
Coronary artery disease
Hypothyroidism

23b. Did tobacco uae contribute to the cauae of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy lindings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☒ Other (Specify) Assisted Living

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred et the time, dete end piece, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Donna Chambers MD

29c. License number: D48101

29d. Date signed (Month, Day, Year): 2/2/2001

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): Donna Chambers MD 8601 Veterans Hwy Suite 204 Millersville MD 21108

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001

32. Registrar's Signature: Donna D Smith

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mentel Hygiene. **Important: if Item 27 is marked other than "naturel", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificete be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

FEB 0 2 2001

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04399

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN FRANCIS BAKER
2. Date of Death — Month: JANUARY Day: 30 Year: 2001
3. Time of Death: 7:30 PM
4a. Facility Name (If not institution, give street and number): SPA CREEK CENTER/GENESIS ELDERCARE
4b. City, Town, or Location of Death: ANNAPOLIS
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 117 10 7607
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 02/08/1915
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Arnold
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 329 Marba Road
10f. Zip Code: 21012
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chairman of the Board/President
16b. Kind of Business/Industry: The Hecht Company

17. Father's Name (First, Middle, Last): Richard J. Baker
18. Mother's Name (First, Middle, Maiden Surname): Clara McAvoy

19a. Informant's Name/Relationship (Type, Print): John F. Baker, Jr. (son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 900 Primrose Road, Apt 304, Annapolis MD 21403

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: 2/1/01
20c. Location - City or Town, State: Alexandria VA

21. Signature of Funeral Service Licensee: Melanie Hilhelm Wagner
22. Name and Address of Facility: Advent Funeral & Cremation Services Annapolis MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Pneumonia — 1 wk

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [illegible]
29c. License number: D32036
29d. Date signed (Month, Day, Year): 1/31/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Capt Sprowl 2108 DiDonato Drive Chester MD 21619

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: [illegible]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

FEB 01 2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 04400

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kathryn Abbey Bowyer

2. Date of Death (Month, Day, Year): January 30, 2001

3. Time of Death: 9:34 AM

4a. Facility Name (If not institution, give street and number): The Memorial Hospital

4b. City, Town, or Location of Death: Easton

4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 235-56-9011

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 5, 1909

9. Birthplace (State or Foreign Country): Texas

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Caroline

10c. City, Town or Location: Preston

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7380 Todds Wharf Road

10f. Zip Code: 21655

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Britton Taber Abbey

18. Mother's Name (First, Middle, Maiden Surname): Merle Mosson

19a. Informant's Name/Relationship (Type, Print): Kitty Adams/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 2310 Easton, MD 21601

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Crematory

Date: 2/1/01

20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: Todd E. Lilley

22. Name and Address of Facility: John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Heart Failure — 12 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of): Massive left cerebral infarction — 18 hours

c. Due to (or as a consequence of): Atrial fibrillation — Weeks

d. Due to (or as a consequence of): Degenerative Coronary Disease — Years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Alzheimers Disease

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Terry L. Detrich

29c. License number: D12893

29d. Date signed (Month, Day, Year): 1/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Terry Detrich 140 S. Washington St. Easton, MD 21601

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001

32. Registrar's Signature: Geneva B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04401

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph W. Bozzi, Sr.

2. Date of Death (Month, Day, Year): January 28, 2001

3. Time of Death: 9:35 A.M.

4a. Facility Name (If not institution, give street and number): 1140 Madison Street

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 579-26-9840

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 30, 1926

9. Birthplace (State or Foreign Country): Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Edgewater

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 860 Holly Avenue

10f. Zip Code: 21037

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1944-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Plumbing Superintendent

16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Frank Bozzi

18. Mother's Name (First, Middle, Maiden Surname): Sarah Webb Moroney

19a. Informant's Name/Relationship (Type, Print): Carla D. Paddy/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 860 Holly Avenue Edgewater, Maryland 21037

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory | Date: 1-29-01

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037

To Be Completed by Funeral Director

mcg Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CANCER HEAD + NECK — 14 mos

Due to (or as a consequence of):
b. CANCER LUNG

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify): Son's Home

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D08118

29d. Date signed (Month, Day, Year): 01/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stanley P. Watkins, M.D. 900 Bestgate Rd. Annapolis, Maryland 21401

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): JAN 3 0 2001

32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND# 8 AACO HEALTH Dept 2/5/01 cmh

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2001 04402

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JANE M. BOWEN
2. Date of Death: Month 01 Day 28 Year 01
3. Time of Death: 11:54 A.M.
4e. Facility Name (If not institution, give street and number): Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 579-42-0820
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): ~~Nov. 11, 1932~~ Nov 12, 1932
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Florida
10b. County: Hernando
10c. City, Town or Location: Ridge Manor
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 33488 Ohio Avenue
10f. Zip Code: 33523
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor
16b. Kind of Business/Industry: Telephone Room

17. Father's Name (First, Middle, Last): John S. Drury
18. Mother's Name (First, Middle, Maiden Surname): Ella Donegan

19e. Informant's Name/Relationship (Type, Print): Wayne C. Cutler/ Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 33488 Ohio Avenue Ridge Manor, FL 33523

20e. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: 1-30-01
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037

To Be Completed by Funeral Director

mcg Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Sepsis — 3 weeks
Due to (or as a consequence of): Staphylococcal Bacteremia — 3 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Renal Failure
Liver cirrhosis
Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Sybrand Beck, MD
29c. License number: D 46052
29d. Date signed (Month, Day, Year): 1/28/01
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Sybrand Beck, MD 64 Franklin Street Annapolis, MD 21401

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04403

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Sarah Estelle Crowe
2. Date of Death Month / Day / Year: January 26, 2001
3. Time of Death: 8:30PM
4a. Facility Name *(If not institution, give street and number)*: Manor Care-Bethesda
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-01-9263
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov. 17, 1918
9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6530 Democracy Boulevard
10f. Zip Code: 20817
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary
16b. Kind of Business/Industry: Health Care

17. Father's Name *(First, Middle, Last)*: William T. Taggart
18. Mother's Name *(First, Middle, Maiden Surname)*: Rebecca Sweet

19a. Informant's Name/Relationship *(Type, Print)*: Patricia C. Knowles/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1515 Clermont Drive, #101, Naples, Florida 34109

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Ft. Lincoln Cemetery — Date: Jan 31 2001
20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: David E. Posey M00803
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only* one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia	1 Week
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Viral Illness	1 Week
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Severe Dementia; Normal Pressure Hydrocephalus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Loreto S. ALbiol MD
29c. License number: D31319
29d. Date signed *(Month, Day, Year)*: January 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Loreto S. ALbiol, M.D. 8218 Wisconsin Avenue, #103, Bethesda, Maryland 20814

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 30 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04404

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MAVIS COX
2. Date of Death (Month, Day, Year): JANUARY 31, 2001
3. Time of Death: 11:40 PM
4a. Facility Name (If not institution, give street and number): 14 OLD CREEK COURT
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 548-37-9806
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 62 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 5, 1938
9. Birthplace (State or Foreign Country): London, U.K.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 14 Old Creek Court
10f. Zip Code: 20854
10g. Citizen of What Country?: Great Britain

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse - Midwife
16b. Kind of Business/Industry: Nursing

17. Father's Name (First, Middle, Last): Herbert Leslie Thornley
18. Mother's Name (First, Middle, Maiden Surname): Mabel Amelia Lilley

19a. Informant's Name/Relationship (Type, Print): Brian M. Cox, Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14 Old Creek Court, Rockville, MD 20854

20e. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: Feb 8, 2001
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: ▶ Michael D. Hubbard
22. Name and Address of Facility: DeVol Funeral Home, 10 E. Deer Park Dr., Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. MULTIPLE MYELOMA	10 YEARS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequenca of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Stephen Staal MD
29c. License number: D18219
29d. Date signed (Month, Day, Year): February 1, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen Staal, M.D., 10810 Connecticut Avenue, Bldg. #2 Kensington, MD 20895

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signature: ▶ Lenora B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04405

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ADA F. COLEMAN
2. Date of Death (Month, Day, Year): JANUARY 29, 2001
3. Time of Death: 4:15 AM
4a. Facility Name (If not institution, give street and number): Wilson Health Care Center
4b. City, Town, or Location of Death: Gaithersburg
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578-62-1836
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 97 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 26, 1903
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: None
10b. County: None
10c. City, Town or Location: Washington, DC
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 423 Oglethorpe Street, NW
10f. Zip Code: 20011
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5+ College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher
16b. Kind of Business/Industry: D.C. Public Schools

17. Father's Name (First, Middle, Last): Robert P. Foreman
18. Mother's Name (First, Middle, Maiden Surname): Martha E. Brown

19a. Informant's Name/Relationship (Type, Print): Elizabeth Williamson (Sister)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 607 Lamont St., NW, Wash. DC 20010

20a. Method of Disposition: ☒ 1 Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lincoln Mem. Cem. Date: 2/5/01
20c. Location - City or Town, State: Suitland, MD

21. Signature of Funeral Service Licensee: George R. Snowden
22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia	week
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes
Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joel Schulman M.D.
29c. License number: D25716
29d. Date signed (Month, Day, Year): January 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joel Schulman, MD 9410 Old Georgetown Rd. Bethesda, MD 20814

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

b

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04406

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anne Marie Code

2. Date of Death Month Day Year: January 24 2001

3. Time of Death: 9:16 P.M.

4a. Facility Name (If not Institution, give street and number): Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 122-24-1745

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Yeer: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): June 15 1932

9. Birthplece (State or Foreign Country): New York

Usuel Residence of Decedent

10a. Stete: MD

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 103 North Summit Avenue

10f. Zip Code: 20877

10g. Citizen of Whet Country?: United States

11. Meritel Stetus: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12): 12

College (1-4or 5+):

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Seamstress

16b. Kind of Business/Industry: Retail

17. Father's Neme (First, Middle, Last): Thomas F. O'Sullivan

18. Mother's Neme (First, Middle, Maiden Surneme): Anna M. Duffy

19e. Informent's Name/Relellonship (Type, Print): John N. Code/ Husband

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 103 North Summit Avenue, Gaithersburg, MD 20877

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stele 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other pleca): Quantico Veteran Cemetery

Dete: January 29, 2001

20c. Locelion - City or Town, State: Triangle, VA

21. Signature of Funeral Service Licensee: Robert H. DeVol

22. Neme end Address of Fecility: DeVol Funeral Home, 10 East Deer Park Drive Gaithersburg, MD 20877

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediete Ceuse (Final diseese or condition resulting in death)

e. Acute Respiratory Failure

Due lo (or es e consequenca of):

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or Injury thet Initieted events resulting in deeth) Lest

b. Acute Left Middle Cerebral Artery Infarct

Due to (or es e consequence of):

c. Right Lung Cancer

Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing lo death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Deeth (Check only one)

Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Locetion (Street and Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medicel Examiner**: On the basis of exemineticn end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner steted.

29b. Signature end title of certifier: Mahnaz Parveen, MD

29c. License number: D45692

29d. Dete signed (Month, Dey, Yeer): 1/25/01.

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Mahnaz Parveen, M.D. 1500 Forest Glen Road, Silver Spring, MD 20901

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 31 2001

32. Registrer's Signeture: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

b

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

12

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04407

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EDITH CHEEFER
2. Date of Death — Month: JANUARY Day: 28, Year: 2001
3. Time of Death: 7:15 AM
4a Facility Name *(If not institution, give street and number)*: CASEY HOUSE-MONTGOMERY HOSPICE
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 101-01-6422
6. Sex: 1☐ M 2☒ F
7. Age *(in yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: APRIL 15, 1918
9. Birthplace *(State or Foreign Country)*: CT.

Usual Residence of Decedent

10a. State: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 824 NW DRIVE
10f. Zip Code: 20901
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE
15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: OFFICE MANAGER
16b. Kind of Business/Industry: INSURANCE
17. Father's Name *(First, Middle, Last)*: LOUIS SILVERMAN
18. Mother's Name *(First, Middle, Maiden Surname)*: SARAH SCHEYER
19a. Informant's Name/Relationship *(Type, Print)*: AARON FINEMAN/SON IN LAW
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13910 FLINT ROACK ROAD, ROCKVILLE, MARYLAND 20853
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MT. LEBANON CEMETERY — Date: JAN 29, 2001
20c. Location - City or Town, State: ADELPHI, MARYLAND
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Ceuse (Finel disease or condition resulting in death)
a. GASTRIC CANCER — 2 YEARS
Due to (or as a consequence of):
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* HOSPICE

27. Manner of Death: 1☒ Neturaf 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: BAC51 9473
29d. Date signed *(Month, Day, Year)*: JANUARY 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHERYL AYLESWORTH, M.D. 6800 GEORGIA AVENUE, WASHINGTON, D.C. 20807

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 29 2001
32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04408

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Claire H. Castle
2. Data of Death Month Day Year: January 21, 2001
3. Time of Death: 2:10 AM
4a. Facility Name *(If not institution, give street and number)*: Casey House
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 400-01-9016
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Mar. 25, 1913
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1213 Elm Grove Circle
10f. Zip Code: 20905
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Nurse
16b. Kind of Business/Industry: Medical

17. Father's Name *(First, Middle, Last)*: Luther Helbert
18. Mother's Name *(First, Middle, Maiden Surname)*: Susie Buchanan

19a. Informant's Name/Relationship *(Type, Print)*: Phillip Castle / Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1213 Elm Grove Circle, Silver Spring, Maryland 20905

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery — Date: 01/25/01
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic Cervical Cancer	2 years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D54378
29d. Date signed *(Month, Day, Year)*: January 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Cheryl Ayelsworth, M.D. 6800 Georgia Avenue, Washington, DC 20807

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 31 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04409

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Leroy Carrick

2. Dete of Deeth — Month: January Day: 31 Yeer: 2001

3. Time of Deeth: 3:32 am

4a Fecility Neme *(If not institution, give street and number)*: Holy Cross Hospital

4b. City, Town, or Location of Deeth: Silver Spring

4c. County of Deeth: Montgomery

Funeral Director

5. Sociel Security Number: 218-16-2041

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. lest birthday)*: 78 Yrs.

If Under 1 Yeer: Months: Deys: If Under 24 Hrs.: Hours: Min.:

8. Dete of Birth *(Month, Dey, Yeer)*: Oct 13, 1922

9. Birthplece *(State or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Beltsville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street end Number: 3732 Evans Trail Way

10f. Zip Code: 20705

10g. Citizen of Whet Country?: USA

11. Meritel Status: 1 [ ] Never Merried 2 [ ] Merried 3 [X] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Rece - Americen Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Printer

16b. Kind of Business/Industry: Printing

17. Fether's Neme *(First, Middle, Last)*: Norvell Carrick

18. Mother's Neme *(First, Middle, Meiden Surneme)*: Edith Wood

19a. Informent's Neme/Relationship *(Type, Print)*: Barbara Carrick Boumboulis (daughter)

19b. Meiling Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 3732 Evans Trail Way, Beltsville, MD 20705

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, crematory or other piece)*: Fort Lincoln Cemetery Date: Feb 3 2001

20c. Location - City or Town, State: Brentwood, MD

21. Signeture of Funerel Service Licensee: Scott Linnell

22. Neme and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Finel disease or condition resulting in deeth): e. Pulmonary Embolism

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

b.

Due to (or es e consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24e. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Plece of Death *(Check only one)*: Hospitel: 1 [X] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Deeth: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Phyeician:** To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end pleca, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Theodore Igwere, MD

29c. License number: D0052921

29d. Date signed *(Month, Dey, Yeer)*: February 1, 2001

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): Theodore Igwere, MD 1500 Forest Glen Road, Silver Spring, MD 20910

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: FEB 02 2001

32. Registrer's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 044,10

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Elena Camantigue
2. Data of Death Month Day Year: January 27, 2001
3. Time of Death: 9:35 pm
4a Facility Name *(If not institution, give street and number)*: Mariner Health Care- Silver Spring
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-66-6364
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 86 Yrs. | If Under 1 Yeer: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug 17, 1914
9. Birthplace *(State or Foraign Country)*: Honduras

Usual Residance of Decedant

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street end Number: 9301 Fernwood Road
10f. Zip Coda: 20817
10g. Citizen of What Country?:
11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowad 4☐ Divorced
12. Was Dacadent Evar in U,S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaer or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☒ Yes 2☐ No *Specify:* Honduran
14. Raca - Amarican Indian, Black, White, atc. *Specify:* White
15. Decedant's Education *(Specify only highast grada complatad)*: Elamentary/Secondery (0-12): 0 | Collega (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Cook
16b. Kind of Business/Industry: Food
17. Fathar's Nama *(First, Middle, Last)*: Rosendo Montes
18. Mothar's Nama *(First, Middle, Maidan Surnama)*: Domitila Garcia
19a. Informant's Name/Ralationship *(Type, Print)*: Priscila Falcon/ Daughter
19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, State, Zip Code)*: 9301 Fernwood Road, Bethesda, MD 20817
20a. Method of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other *(Specify)*
20b. Placa of Disposition *(Name of camatary, cramatory or othar placa)*: Metropolitan Crematory
Data: Jan 31 2001
20c. Location - City or Town, State: Alexandria, VA
21. Signature of Funeral Service Licensee: Robert E Lamey
22. Nama and Addrass of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disaasa or condition rasulting in daath)
a. Pneumonia — 2 weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immadiata cause. Entar Undarlying Cause (Disease or injury that initiated evants rasulting in daath) Last
b.
Due to (or es e consequanca of):
c.
Dua to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the undarlying cause given in Part I.: severe dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to complation of cause of death? 1☐ Yas 2☒ No

25. Wes casa rafarrad to medical examiner? 1☐ Yas 2☒ No

26. Placa of Death *(Chack only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Othar: 4☒ Nursing Home 5☐ Residence 6☐ Othar *(Specify)*

27. Manner of Daath: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Routa Number, City or Town, State)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurrad at tha tima, data and placa, and dua to tha cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signeture and title of cartifiar: Rod Rosenbaum
29c. License number: D 09834
29d. Data signad *(Month, Day, Year)*: January 30, 2001

30. Name and addrass of person who complatad cause of daath (Item 23a) (Type, Print): Barry Rosenbaum 3720 Farragut Ave., Kensington, MD 20895

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 31 2001
32. Registrer's Signature: Renee G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04411

Amend item #26 per hospital. 2/6/2001 mp

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EDWARD MATTHEWS CLARK
2. Date of Death (Month, Day, Year): JANUARY 31, 2001
3. Time of Death: 11:37 AM
4a. Facility Name (If not institution, give street and number): SOUTHERN MARYLAND HOSPITAL CENTER
4b. City, Town, or Location of Death: CLINTON
4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 220-28-6236
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 68 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JANUARY 25, 1933
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: PRINCE GEORGE'S
10c. City, Town or Location: BRANDYWINE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 15810 MCKENDREE ROAD
10f. Zip Code: 20613
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 1953-1955
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ROOFER ESTIMATOR
16b. Kind of Business/Industry: COMMERCIAL & RESIDENTIAL CONSTRUCTION

17. Father's Name (First, Middle, Last): GEORGE LEE CLARK
18. Mother's Name (First, Middle, Maiden Surname): EVELYN ROSE CURTIN

19a. Informant's Name/Relationship (Type, Print): ALEENE MAE CLARK/WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15810 MCKENDREE ROAD, BRANDYWINE, MARYLAND 20613

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MARYLAND VETERANS
Date: 2/07/2001
20c. Location - City or Town, State: CHELTENHAM, MARYLAND

21. Signature of Funeral Service Licensee: JOHN P. KNISLEY M01164 JPK
22. Name and Address of Facility: THE HUNTT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604-0156

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. MYOCARDIAL INFARCTION
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Coronary HEART Disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: ATrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: M.H. Chaudhry MD
29c. License number: D-14364
29d. Date signed (Month, Day, Year): 2-1-01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M.H. CHAUDHRY MD. 7610 Carroll Ave #300, Takoma PK, Md, 20912.

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001
32. Registrar's Signature: Denise G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04412

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARGARET MARY COLEMAN
2. Date of Death: Month: February Day: 1 Year: 2001
3. Time of Death: 1948
4a. Facility Name (If not institution, give street and number): Union Hospital
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 222-50-2770
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 62 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN 16, 1939
9. Birthplace (State or Foreign Country): Delaware

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Elkton
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 110 Kirk Road
10f. Zip Code: 21921
10g. Citizen of What Country?: United States
11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: In Her Own Home
17. Father's Name (First, Middle, Last): Charles Coleman
18. Mother's Name (First, Middle, Maiden Surname): Teresa A. Kooker
19a. Informant's Name/Relationship (Type, Print): Christine M. Goodyear/Guardian Legal
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 1747, Elkton, Maryland 21922
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): R.A. Ferris & Co. Inc.
Date: 2/5/01
20c. Location - City or Town, State: West Chester, PA
21. Signature of Funeral Service Licensee: Donald S. Hicks
22. Name and Address of Facility: Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. COLON CANCER WITH DIFFUSE PELVIC CARCINOMATOSIS

Due to (or as a consequence of):
b. COLONIC OBSTRUCTION S/P LAPAROTOMY

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. LARGE INTESTINAL ADHESION S/P LAPAROTOMY

Due to (or as a consequence of):
d. ANEMIA

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D56820
29d. Date signed (Month, Day, Year): 2/1/01 10:51PM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOSEPH NISNISAN MD 223 W. MAIN ST. ELKTON MD 21921

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04413

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HARRY ROBERT COOK
2. Date of Death (Month Day Year): February 4 2001
3. Time of Death: 1:30am
4a. Facility Name (If not institution, give street and number): 13848 Sassafras Rd.
4b. City, Town, or Location of Death: Galena
4c. County of Death: Kent

Funeral Director

5. Social Security Number: 173-26-2009
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 5 1930
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: Kent
10c. City, Town or Location: Galena
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 13848 Sassafras Rd.
10f. Zip Code: 21635
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: 1954 -1957
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired): High School English Teacher
16b. Kind of Business/Industry: New Castle County High School

17. Father's Name (First, Middle, Last): Harry O. Cook
18. Mother's Name (First, Middle, Maiden Surname): Adelaide Newman

19a. Informant's Name/Relationship (Type, Print): Shirley Horton Cook wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13848 Sassafras Rd. Galena, MD. 21635

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Kent Cremation Service | Date: 2/4/01
20c. Location - City or Town, State: Smyrna, DE.

21. Signature of Funeral Service Licensee: M00510
22. Name and Address of Facility: Galena Funeral Home of Stephen Schaech 118 West Cross St. Galena, MD. 21635

Physician /Medical Examiner

RGW

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. metastatic Prostate Ca — >2yo

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D 36054
29d. Date signed (Month, Day, Year): 2/4/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Patrick J. Shanahan MD 120 Speer Rd. Chestertown, MD. 21620

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001
32. Registrar's Signature: pennie P. Sparks

5+ IVA

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

CPS
01-0496-003
BARBARA CAPPS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04414

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Barbara S. Capps
2. Date of Death Month Day Year: January 29, 2001
3. Time of Death: 05:19 AM
4a. Facility Name (If not institution, give street and number): 2060 Shore Drive
4b. City, Town, or Location of Death: Edgewater
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 579-52-5629
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 62 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 9, 1938
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Edgewater
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2060 Shore Drive
10f. Zip Code: 21037
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2yrs.
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Choreographer
16b. Kind of Business/Industry: Theatre

17. Father's Name (First, Middle, Last): Joseph R. Smith
18. Mother's Neme (First, Middle, Maiden Surneme): Josephine N. Emelio

19a. Informant's Name/Relationship (Type, Print): Lea Capps/ Daughter
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code): 2906 Winters Chase Way Annapolis, Maryland 21401

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Metropolitan Crematory
Date: 1-31-01
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Robert Walter
22. Name and Address of Facility: George P. Kalas Funeral Home 2973 Solomons Island Rd,. Edgewater, MD 21037

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in deeth)
a. Metastatic Adenocarcinoma

~~Due to (or as a consequence of):~~

Sequentially fist conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. OF Pancreas
Due to (or as a consequenca of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Atherosclerotic Cardiovascular Disease

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No
24b. Were autopsy findings available prior to compiation of ceuse of death? 1☑ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one)
Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) SCENE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Data of Injury (Month, Dey Year)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner es steted. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end piece, and due to the cause(s) end menner steted.

29b. Signature and title of certifier: Joseph Pestaner, M.D.
29c. Licensa number: OCME
29d. Date signed (Month, Day, Year): January 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001
32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-0400-510
crn
Wallace Campbell, Jr.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04415

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WALLACE CAMPBELL JR.
2. Date of Death (Month, Day, Year): January 24, 2001
3. Time of Death: 2:20 P.M.
4a. Facility Name (If not institution, give street and number): 3745 St. Victor Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 251-62-2364
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 62 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): FEB. 5 1938
9. Birthplace (State or Foreign Country): S. CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: ☒ 1 Yes 2 ☐ No
10e. Street and Number: 3745 ST. VICTOR STREET
10f. Zip Code: 21225
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12th; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SUPERVISOR
16b. Kind of Business/Industry: PRINCE GEORGES CO. SCHOOL

17. Father's Name (First, Middle, Last): WALLACE CAMPBELL SR.
18. Mother's Name (First, Middle, Maiden Surname): ELLA MAE JACOBS

19a. Informant's Name/Relationship (Type, Print): VICKI CAMPBELL (DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 615 ARCH ST. HIGH POINT, N. CAROLINA 27260

20a. Method of Disposition: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): ANNAPOLIS MEM. GARDENS — Date: 1/31/01
20c. Location - City or Town, State: ANNAPOLIS, MD.

21. Signature of Funeral Service Licensee: Larry G. Reese #1600483
22. Name and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

To Be Completed by Funeral Director

mcg

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic Cardiovascular Disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? ☒ 1 Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) at scene

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the ceuse(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: O.C.M.E.
29d. Date signed (Month, Dey, Year): January 25, 2001
30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Dete filed (Month, Day, Year): JAN 3 0 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04416

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Betty Jo Carty
2. Date of Death Month / Day / Year: Jan 27, 2001
3. Time of Death: 1:00 pm
4e. Facility Name *(If not institution, give street and number)*: 407 Golf Course Drive
4b. City, Town, or Location of Death: Arnold
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 465-42-9172
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 71 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 29, 1929
9. Birthplace *(State or Foreign Country)*: Texas

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Arnold
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 407 Golf Course Drive
10f. Zip Code: 21012
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: Lamar Hibbitts
18. Mother's Name *(First, Middle, Maiden Surname)*: Hattie Hayes

19e. Informant's Name/Relationship *(Type, Print)*: Edward Carty/Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 407 Golf Course Drive Arnold, MD 21012

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory
Date: Feb. 2 2001
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: James E. Barranco
22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Esophageal Cancer — 10 Months

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Janet Cooper MD
29c. License number: D46118
29d. Date signed *(Month, Day, Year)*: Jan 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JANET COOPER, MD 1447 York Rd Lutherville MD 21093

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 01 2001
32. Registrar's Signature: P Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04417

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JULIA ELIZABETH DERR
2. Date of Death: Month JANUARY Day 31 Year 2001
3. Time of Death: 1:15am
4a. Facility Name (If not institution, give street and number): National Institute Of Health
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 218-38-4404
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 62 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 24, 1938
9. Birthplace (State or Foreign Country): China

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10201 Grosvenor Pl. #1011
10f. Zip Code: 20852
10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Asian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): – College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Management Analyst
16b. Kind of Business/Industry: National Institutes Of Health

17. Father's Name (First, Middle, Last): Jeffrey Derr
18. Mother's Name (First, Middle, Maiden Surname): Phyllis Liang

19a. Interment's Name/Relationship (Type, Print): Jeffrey Derr/ Brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 20564 Afternoon Lane, Germantown, Maryland 20874

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc.
Date: February 5, 2001
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: M00689
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Cardiogenic shock	24 hrs
Due to (or as a consequence of): b.	Septic Shock	48 hrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): c.	Perforated Viscus	48 hrs
Due to (or as a consequence of): d.	leiomyosarcoma carcinomatosis	~6 wks

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I: Leiomyosarcoma Carcinomatosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Giao Phan, MD
29c. License number: D0056250
29d. Date signed (Month, Day, Year): 01/31/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GIAO PHAN 9000 ROCKVILLE PIKE, BETHESDA, MD 20892

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04418

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BRUCE JOSEPH DeHAVEN
2. Date of Death (Month, Day, Year): January 28, 2001
3. Time of Death: 5:20P.
4a. Facility Name (If not institution, give street and number): Laurel Regional Hospital
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 213-78-2279
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 45 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 21, 1955
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Beltsville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4615 Greenwood Road
10f. Zip Code: 20705
10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Landscaping
16b. Kind of Business/Industry: private

17. Father's Name (First, Middle, Last): Harry F. DeHaven
18. Mother's Name (First, Middle, Maiden Surname): Mary G. Quinn

19a. Informant's Name/Relationship (Type, Print): Harry F. DeHaven - Father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as 10a - 10g

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): George Washington Cemetery
Date: 2/1/01
20c. Location - City or Town, State: Adelphi, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Acute Cardiac Arrest	sudden
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Chronic Congestive Heart Failure	1987
Due to (or as a consequence of):		
c.	Dilated Myocardiopathy	1987
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Seminoma of Testicle

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.
29c. License number: D13339
29d. Date signed (Month, Day, Year): January 28, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): T. Chan Chien, M.D. 8824 Cunningham Drive Berwyn Heights, Maryland 20740

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

GF

3

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04419

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RUTH ELIZABETH SIMMONS DRESSER

2. Date of Death: Month Feb Day 4 Year 2001

3. Time of Death: 5:35 AM

4e. Facility Name (If not institution, give street and number): Charles County Nursing Rehab Center

4b. City, Town, or Location of Death: La Plata

4c. County of Death: Charles

Funeral Director

5. Social Security Number: 577-10-2663

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 95 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): September 24, 1905

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10e. State: MD

10b. County: Charles

10c. City, Town or Location: La Plata

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 10200 La Plata Road

10f. Zip Code: 20646

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 4

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Publications Editor

16b. Kind of Business/Industry: US Govt.

17. Father's Name (First, Middle, Last): Calvin Simmons

18. Mother's Name (First, Middle, Maiden Surname): Nannie Maroughy Simmons

19a. Informant's Name/Relationship (Type, Print): Cecil Simpson/Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12626 Plow Crt. FAirfax,VA. 22030

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Central Cemetery

Date: 2/7/01

20c. Location - City or Town, State: Barstow,Maryland

21. Signature of Funeral Service Licensee: David C. Echols M00945

22. Name and Address of Facility: AREHART-ECHOLS FUNERAL HOME,P.A. P.O. BOX 567 LA PLATA,MD. 20646

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Congestive heart failure	3 days
Due to (or as a consequence of):	b. Tachycardia	3 dy.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. atrial fibrosis	2 dy.
Due to (or as a consequence of):	d. Pleural effusion	1 dy

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus type II

Generalized arteriosclerosis with renal changes

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Arthur O. Wooddy MD

29c. License number: D11176

29d. Date signed (Month, Day, Year): Feb 4, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Arthur O. Wooddy,MD P.O. Box 430 La Plata,MD 20646

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001

32. Registrar's Signature: Penny B. Sparks

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Ruth Dresser

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04420

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Harry Thomas Davis, Jr.
2. Data of Death Month/Day/Year: January 31, 2001
3. Time of Death: 3:05 PM
4a. Facility Name (If not institution, give street and number): 1119 Chester Road
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 178-26-8656
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Nov. 18, 1931
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residance of Decedant

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [ ] Yas 2 [X] No
10e. Street and Number: 1119 Chester Road
10f. Zip Coda: 21220
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1 [X] Yas 2 [ ] No If Yas, Giva Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, afc.) 1 [ ] Yas 2 [X] No Specify:
14. Race - American Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired): Firefighter
16b. Kind of Business/Industry: Baltimore City Fire Department

17. Fathar's Nama (First, Middle, Last): Harry Thomas Davis, Sr.
18. Mother's Neme (First, Middle, Maiden Surnama): Freida Burge

19a. Informent's Neme/Raletionship (Type, Print): Mrs. Dorothy A. Davis (wife)
19b. Mailing Addrass (Straet and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 1119 Chester Road, Baltimore, MD 21220

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cramation 3 [ ] Ramoval from Steta 4 [ ] Donetion 5 [ ] Othar (Specify)
20b. Place of Disposition (Nama of cematary, cramatory or othar placa): Holly Hill Mem'l Gardens
Date: 2/5/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signafura of Funaral Service Licensaa: Brian A. Willen
22. Nama and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha mode of dying, such as cardiac or respiratory arrast, shock, or haart failura. List only one ceuse on aach lina.

		Approximata Interval Between Onset and Death
Immediate Cause (Final disaase or condition resulting in deeth) a.	METASTATIC CANCER of SALIVARY GLAND	18 MOS
Dua to (or as a consaquence of): b.		
Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Diseesa or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.		
Dua fo (or as a consaquanca of): d.		

Parl II. **Other significant conditions** contributing to death but not rasulting in the undarlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Wara autopsy findings eveilable prior fo completion of cause of death? 1 [ ] Yas 2 [X] No

25. Wes case referred to medical examinar? 1 [ ] Yas 2 [X] No

26. Placa of Death (Check only ona)
Hospitel: 1 [ ] Inpatiant 2 [ ] ER/Outpetient 3 [ ] DOA
Other: 4 [ ] Nursing Homa 5 [X] Rasidance 6 [ ] Othar (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Panding invastigetion 6 [ ] Could not be detarmined

28a. Data of Injury (Month, Dey Year)
28b. Tima of Injury M
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Dascribe how injury occurred
28a. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifiar (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, daath occurred at tha tima, data and placa, and dua to the causa(s) and manner as stated. 2 [ ] **Medical Examiner:** On tha basis of exemination and/or investigation, in my opinion, daath occurred at tha time, date and place, and due to tha ceuse(s) and manner stated.

29b. Signature and title of certifier:
29c. Licansa number: D33551
29d. Date signed (Month, Day, Year): Feb 2, 2001

30. Nama and addrass of parson who complated causa of daath (Item 23a) (Type, Print): MICHAEL AUERBACH 9000 FRANKLIN SQUARE Dr, Baltimore 21237

State Registrar

31. Data filed (Month, Day, Year): FEB 8 2001
32. Registrar's Signatura: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04421

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Berlin Harold Dean
2. Data of Death Month Day Year: January 28, 2001
3. Time of Death: 23:00
4a Facility Name *(If not institution, give street and number)*: Union Hospital of Cecil County
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 234-44-4340
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 71 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 29, 1929
9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: North East
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 20 Cemetery Road
10f. Zip Code: 21901
10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Groundskeeper
16b. Kind of Business/Industry: Country Club

17. Father's Name *(First, Middle, Last)*: Leonard Henry Dean
18. Mother's Name *(First, Middle, Maiden Surname)*: Lillie Mae Butterball

19a. Informant's Name/Relationship *(Type, Print)*: Laura Dean / Spouse
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 20 Cemetery Road, North East, Maryland 21901

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: North East Methodist Cemetery
Date: February 1, 2001
20c. Location - City or Town, State: North East, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Crouch Funeral Home, 127 South Main Street, North East, Maryland 21901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Prostate Cancer — MONTHS

Due to (or as a consequence of):
b. Chronic Obstructive Pulmonary Disease — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D0047711
29d. Date signed *(Month, Day, Year)*: January 29, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID GAR-EL 3 MALDOW AVENUE NORTH EAST MARYLAND 21901

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 31 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04422

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bettie G. Etchison

2. Date of Death: Month January Day 24 Year 2001

3. Time of Death: 11:50 AM

4a. Facility Name (If not institution, give street and number): Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 213-38-3004

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 28, 1917

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Kensington

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4417 Clearbrook Lane

10f. Zip Code: 20895

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Registered Nurse

16b. Kind of Business/Industry: Hospital

17. Father's Name (First, Middle, Last): Gurney Gosnell

18. Mother's Name (First, Middle, Maiden Surname): Virginia E. Layman

19a. Informant's Name/Relationship (Type, Print): Elgin M. Etchison/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15300 Bunchberry Court, Gaithersburg, MD 20878

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc.

Date: January 28,2001

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: Robert A. Pumphrey M00198

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Pneumonia — 1 week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Dehydration

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Alan Diamond MD

29c. License number: 24245

29d. Date signed (Month, Day, Year): January 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alan Diamond, M.D. 10801 Lockwood Drive, Silver Spring, Maryland 20901

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001

32. Registrar's Signature: Brenda B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.** b

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

DHMH 16 Rev 6/95

ORIGINAL

01-0513-033
jhm
JOHN
EDWARDS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04423

AMENDED ITEMS# 23a,ptII,27&28a-f per ME G792 03020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Dey Yeer	3. Time of Death
JOHN EDWARDS	JANUARY 30, 2001	17:40 PM

4a. Facility Name (If not institution, give street end number)	4b. City, Town, or Location of Death	4c. County of Death
PRINCE GEORGES HOSPITAL	CHEVERLY	PRINCE GEORGES

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Yeer: Months / Deys	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Dey, Yeer)	9. Birthplece (State or Foreign Country)
249-12-8605	1[X] M 2[ ] F	81 Yrs.			08/11/1919	SOUTH CAROLINA

Usuel Residence of Decedent

10a. Stete	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	P.G.	HYATTSVILLE	1[X] Yes 2[ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
7603 NORMANDY RD.	20785	U.S.A.

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Bleck, White, etc.
1[ ] Never Merried 2[ ] Merried 3[X] Widowed 4[ ] Divorcad	1[ ] Yes 2[ ] No If Yes, Give Yeer or Dates: 1943 1945	1[ ] Yes 2[X] No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
9th		RAIL ROAD FORMAN	N/A

17. Fether's Neme (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Sumame)
WILLIE EDWARDS	LULA EDWARDS

19e. Informent's Neme/Reletionship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
WILSON HARRIS (GRANDSON)	7603 NORMANDY RD. HYATTSVILLE MD. 20785

20e. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, State
1[X] Buriel 2[ ] Cremetion 3[ ] Removal from Stete 4[ ] Donetion 5[ ] Other (Specify)	FT. LINCOLN CEMETERY	01/5/01	BRENTWOOD MARYLAND

21. Signeture of Funeral Service Licensee	22. Neme end Address of Facility
	AUSTIN ROYSTER FUNERAL HOME 3821 14th ST. N.W. WASH. D.C. 20011

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximete Interval Between Onset end Death

Immediate Cause (Finel diseese or condition resulting in death)
a. STATUS POST COLONOSCOPY

Due to (or as a consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last
b.

Due to (or es a consequenca of):
c.

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[ ] No 3[ ] Probably 4[X] Unknown

24e. Wes en eutopsy performed?	24b. Were eutopsy findings eveilable prior to completion of cause of deeth?
1[X] Yes 2[ ] No	1[X] Yes 2[ ] No

25. Wes case referred to medical exeminer?	26. Place of Deeth (Check only one)	
1[X] Yes 2[ ] No	Hospital: 1[ ] Inpetient 2[X] ER/Outpetient 3[ ] DOA	Other: 4[ ] Nursing Home 5[ ] Residence 6[ ] Other (Specify)

27. Manner of Deeth	28e. Dete of Injury (Month, Dey Yeer)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1[ ] Netural 2[X] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigetion 6[ ] Could not be determined	01-26-01	unknown M	1[ ] Yes 2[X] No	colonoscopy procedure

28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, Stete)
hospital	Prince George's Co Hosp., Cheverly,MD

29a. Certifier (Check only one)
1[ ] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner es steted.
2[X] **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier	29c. License number	29d. Dete signed (Month, Dey, Yeer)
Dennis J Chute MD	OCME	JANUARY 31, 2001

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print)
Dennis Chute MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Dey, Yeer)	32. Registrer's Signeture
FEB 02 2001	Bruce G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04424

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CYNTHIA MAY FOOTE
2. Date of Death (Month, Day, Year): JANUARY 29, 2001
3. Time of Death: 8:05 PM
4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital
4b. City, Town, or Location of Death: Clinton
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 579-04-5778
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 3, 1927
9. Birthplace (State or Foreign Country): Jamaica

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Upper Marlboro
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3619 Endsley Place
10f. Zip Code: 20772
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Headley Foote
18. Mother's Name (First, Middle, Maiden Surneme): Irene Vacinnia

19a. Informent's Name/Reletionship (Type, Print): Elizabeth West (Daughter)
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 3619 Endsley Pl., Upper Marlboro, MD 20772

20a. Method of Disposition: 1☐ Buriel 2☐ Cremation 3☒ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Pleca of Disposition (Neme of cemetery, cremetory or other piece): Honeyghans Funeral Hm
Date: 2/7/01
20c. Location - City or Town, State: Westmoreland, Jamaica

21. Signature of Funeral Service Licensee: George K. Snowden
22. Neme end Address of Feclity: SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failura. List only one cause on eech line.

Approximete Interval Between Onset end Death

Immediate Cause (Finel disease or condition resulting in death): a. Cardiopulmonary arrest
Due to (or as a consequence of): b. Myocardial infarction
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest:
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☑ Yes 2☐ No
26. Plece of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) end menner as steted. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner steted.

29b. Signature and title of certifier: Opesanmi
29c. License number: D 43606
29d. Dete signed (Month, Dey, Year): 1/30/01

30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print): OBAFEMI OPESANMI 7503 Surratts Rd Clinton, MD

State Registrar

31. Dete filed (Month, Dey, Year): FEB 02 2001
32. Registrer's Signeture: Donna D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.** b

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

5 (1)

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04425

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LUCY BOUVIER FOA

2. Date of Death: Month JAN. Day 25, Year 2001

3. Time of Death: 1:45 PM

4a Facility Name *(If not institution, give street end number)*: MANOR CARE, ARDEN COURTS

4b. City, Town, or Location of Death: POTOMAC

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 014-16-2316

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 82 Yrs.

If Under 1 Yaar: Months / Days

If Undar 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: DEC. 1, 1918

9. Birthplaca *(Stata or Foraign Country)*: MASS.

Usual Residenca of Decedent

10a. Stata: MD.

10b. County: MONTGOMERY

10c. City, Town or Location: BETHESDA

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 9707 OLD GEORGETOWN RD.

10f. Zip Coda: 20814

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Give Yaar or Detas:

13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Raca - Amarican Indian, Black, Whita, atc. *Specify:* WHITE

15. Decedant's Education *(Specify only highast grada complatad)*: Elementary/Secondary (0-12): / College (1-4or 5+): 4

16a. Decedant's Usuel Occupation *(Giva kind of work dona during most of working lifa. DO NOT use retired)*: RET.- TEACHER

16b. Kind of Businass/Industry: SCHOOL

17. Fathar's Nama *(First, Middla, Last)*: ARTHUR BOUVIER

18. Mothar's Nama *(First, Middla, Maidan Sumama)*: FLORE BELLENOIT

19a. Informant's Name/Ralationship *(Type, Print)*: LELIA FOA DYER/DAUGHTER

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 12112 LITTLE CREEK DR., ROCKVILLE, MD. 20854

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cematary, cramatory or othar place)*: CHAMBERS CREMATORY

Data: 1/26/01

20c. Location - City or Town, State: RIVERDALE, MD.

21. Signatura of Funaral Sarvice Licansee: W.W. Chambers M00091

22. Nama and Addrass of Facility: 5801 CLEVELAND AVE. CHAMBERS FUNERAL HOMES,P.A., RIVERDALE, MD.20737

Physician /Medical Examiner

23a. Part1. Entar tha disaase, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart tailura. List only one ceusa on aach lina.

Approximata Intervel Batween Onsat and Death

Immediata Causa (Final disaase or condition rasulting in death)

a. MYOCARDIAL INFARCTION

Dua to (or as a consequanca of):

Sequentially list conditions, if any, laading to immadiata cause. Enter Undarlying Cause (Disease or injury that initiated evants rasulting in death) Last

b.

Due to (or as a consequanca of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to daath but not rasulting in tha underlying cause givan in Part I.: ALZHEIMER'S DISEASE

23b. Did tobacco uss contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings eveileble prior to complation of cause of death? 1☐ Yas 2☐ No

25. Was casa raferrad to medical examiner? 1☐ Yas 2☒ No

26. Place of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Othar: 4☒ Nursing Homa 5☐ Rasidanca 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding Invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledge, death occurred at the tima, data and place, end dua to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, daath occurred at the tima, data and placa, and dua to the ceuse(s) and mannar stated.

29b. Signature and title of certifier: MD

29c. Licensa number: D26259

29d. Data signed *(Month, Day, Year)*: 1/26/01

30. Nama and addrass of person who completed cause of daath (Item 23a) (Type, Print): AVA A KAUFMAN,MD 4930 DEL RAY BETHESDA,MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 29 2001

32. Registrar's Signatura: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

1 (20)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04426

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Constance M. Fishwick

2. Data of Death Month Day Yaar: January 31, 2001

3. Tima of Death: 3:50 pm

4a Facility Nama *(If not institution, giva street and number)*: Montgomery Hospice- Casey House

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 261-60-3654

6. Sex: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yaar)*: Aug 9, 1913

9. Birthplaca *(Stata or Foraign Country)*: Pennsylvania

Usual Rasidence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 5800 Edson Lane

10f. Zip Coda: 20852

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Giva Yaar or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Amarican Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elamentary/Secondary (0-12): 3 / College (1-4or 5+):

16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT usa ratired)*: Registered Nurse

16b. Kind of Business/Industry: Medical

17. Father's Nama *(First, Middla, Last)*: William Mayesky

18. Mothar's Name *(First, Middla, Maidan Surnama)*: Veronica Zorsky

19a. Informant's Name/Relationship *(Type, Print)*: Edward Fishwick / Son

19b. Mailing Addrass *(Straat and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 5800 Edson Lane, Rockville, MD 20852

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from State 4☐ Donation 5☐ Othar *(Specify)*

20b. Piece of Disposition *(Neme of camatary, cramatory or othar placa)*: Metropolitan Crematory

Date: Feb 1 2001

20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: [signature]

22. Nama and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet ceused the death. Do not anter the moda of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only ona causa on aach lina.

Approximata Intarval Batween Onset and Death

Immediate Cause (Finel diseasa or condition rasulting in death)

a. Cerebroatherosclerosis — years

Due to (or as e consequence of):

b. Generalized Atherosclerosis — years

Sequentially list conditions, if any, leading to immedieta cause. Entar Underlying Cause (Diseese or injury that initieted events rasulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco usa contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings evailable prior to completion of ceuse of death? 1☐ Yas 2☒ No

25. Was case referred to medical examinar? 1☐ Yas 2☒ No

26. Placa of Death *(Check only one)*

Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Homa 5☐ Rasidance 6☒ Othar *(Specify)* Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28e. Place of Injury - At home, farm, straat, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, daath occurred at tha tima, data and place, and dua to the ceuse(s) end mennar as statad. 2☐ **Medical Examiner:** On the basis of examinetion and/or invastigation, in my opinion, daath occurred at the time, dete and place, and dua to tha ceuse(s) and manner stated.

29b. Signatura and title of cartifiar: [signature] MD

29c. Licansa number: D 15046

29d. Date signad *(Month, Day, Yaar)*: February 1, 2001

30. Nama and addrass of person who completed causa of daath (Item 23e) (Type, Print): Stephan Newman 19261 Montgomery Village Ave., Montgomery Village, MD 20886

State Registrar

31. Data filed *(Month, Day, Yaar)*: FEB 02 2001

32. Registrar's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04427

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ESTHER H. FIELDS
2. Deta of Deeth — Month: JANUARY Day: 26 Year: 2001
3. Time of Deeth: 10:36 PM
4a Facility Nema *(If not institution, give street end number)*: Holy Cross Hospital
4b. City, Town, or Location of Deeth: Silver Spring
4c. County of Deeth: MONTGOMERY

Funeral Director

5. Social Security Number: 422-05-2360
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 86 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 5, 1914
9. Birthplece *(Stete or Foreign Country)*: Alabama

Usuel Residence of Decedent

10a. Stete: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 1316 Fenwick Lane, #1102
10f. Zip Code: 20910
10g. Citizen of Whet Country?: U.S.A.

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No — If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - Americen Indian, Black, White, etc. *Specify:* Black

15. Decedent's Eduction *(Specify only highest greda completed)*: Elemantary/Secondary (0-12): — College (1-4or 5+): 5+
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use ratired)*: School Teacher
16b. Kind of Businass/Industry: Education

17. Fathar's Nema *(First, Middle, Last)*: Will Hamilton
18. Mother's Nama *(First, Middla, Maidan Surname)*: Maggie McClain

19a. Informent's Name/Relationship *(Type, Print)*: Sharon Cummings (Daughter)
19b. Meiling Address *(Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 9505 Flower Ave., Silver Spring, MD 20901

20e. Mathod of Disposition: 1☐ Burial 2☐ Cremetion 3☒ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Nama of cemetery, cremetory or other place)*: Royal Funeral Home — Date: 1/30/01
20c. Location - City or Town, Steta: Huntsville, AL

21. Signature of Funeral Service Licensee: Burga K. Snowden
22. Name and Address of Fecility: SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or haart failure. List only one causa on each line.

		Approximete Intarvel Betwean Onsat end Death
Immediate Causa (Final disaasa or condition resulting in deeth) e.	Congestive Heart Failure	6 days
Due to (or es e consequence of):		
Sequentially list conditions, if any, leading to immedieta ceuse. Enter Underlying Ceuse (Disaasa or injury that initieted events resulting in death) Lest b.	Acute Myocardial Infarction	6 days
Due to (or es e consequence of):		
c.		
Dua to (or as e consequenca of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Pneumonia

23b. Did tobacco use contribute to the cauae of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings aveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☒ No
26. Piece of Death *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Homa 5☐ Residence 6☐ Other *(Specify)*
27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Data of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Spacify)*
28f. Location *(Straet end Number or Rural Route Number, City or Town, Steta)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the bast of my knowladga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner**: On tha basis of axamination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and mannar stated.

29b. Signature and title of certifier: Phillip W. Poth, M.D.
29c. Licensa number: D22309
29d. Date signed *(Month, Dey, Year)*: Jan. 27, 2001

30. Neme end eddress of person who completed causa of deeth (Item 23e) (Type, Print): Phillip W. Poth, M.D. 9013 Flower Ave., Silver Spring, MD 20901

State Registrar

31. Data filed *(Month, Dey, Year)*: JAN 30 2001
32. Registrer's Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law requires that the daath certificate be executed within 24 hours after death.
To the Funeral Director: Aftar this cartificata has been signed by tha attanding physician and completely filled in by tha funeral director, paga 2 should be detached for usa as the burial-transit

AMEND#10b 1/31/01 AACO HEALTH CMH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 04428

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
MARY FISHER	JAN. 24 2001	8:40 pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SUNRISE ASSISTED LIVING	SEVERNA PARK	ANNE ARUNDEL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-30-9265	1☐M 2☒F	85 Yrs.			DEC. 7 1915	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	~~ANNE ARUNDEL~~ N/A	BALTIMORE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3330 BURLEITH AVENUE	21215	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8th	0	DOMESTIC	OUT OF THE HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
SAM MACKELL	RACHEL CARROLL

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JOYCE JENNINGS (COUSIN)	8300 HOPE POINT COURT MILLERSVILLE, MD. 21108

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	ASBURY TOWN NECK	2/1/01	SEVERNA PARK, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Larry H. Reese #100483	WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Ischemic cardiomyopathy	months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes, renal insufficiency

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Assisted Living Facility

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D41955	1-30-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rebecca Don MD 479 Jumpers Hole Rd Severna Park MD 21146

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 31 2001	

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

JAN 3 3 1980

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04429

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sarajane R. Foster
2. Date of Death (Month, Day, Year): January 30, 2001
3. Time of Death: 3:00 PM
4a. Facility Name (If not institution, give street and number): Ginger Cove Health Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 561-70-6633
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 31, 1919
9. Birthplace (State or Foreign Country): Illinois

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1102 River Crescent Drive
10f. Zip Code: 21401
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own home

17. Father's Name (First, Middle, Last): John W. Reese
18. Mother's Name (First, Middle, Maiden Surname): Eulala Ward

19a. Informant's Name/Relationship (Type, Print): Richard E. Foster / husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1102 River Crescent Drive Annapolis, MD. 21401

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Ft. Lincoln Crematory
Date: 2-1-01
20c. Location - City or Town, State: Brentwood, MD.

21. Signature of Funeral Service Licensee: ▶ Brian Powell
22. Name and Address of Facility: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD. 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): e. CANCER LUNG
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D24768
29d. Date signed (Month, Day, Year): 1/31/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DASS, MD, 277 Pen. Farm Rd., Arnold, Md 21012

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04430

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lethel C. Grant
2. Date of Death (Month, Day, Year): January 25, 2001
3. Time of Death: 2:20 pm
4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 105-68-4731
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 54 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 20,1946
9. Birthplace (State or Foreign Country): Jamaica

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Lanham
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6928 Heidelburg Road
10f. Zip Code: 20706
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher
16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Ezekiel Lawrence
18. Mother's Name (First, Middle, Maiden Surname): Estella Gordon

19a. Informant's Name/Relationship (Type, Print): Vyris I. Clayton (sister)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6928 Heidelburg Road Lanham, Maryland 20706

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery
Date: Feb.3, 2001
20c. Location - City or Town, State: Silver Spring,Maryland

21. Signature of Funeral Service Licensee: James E Dooley
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W.,Silver Spring,MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Multiple Mylona — 2years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Dipi Lal Sinh
29c. License number: D45660
29d. Date signed (Month, Day, Year): 1/25/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 14300, Gallant Fox LN, Bowie MD 20715

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04431

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Gary A. Gordon
2. Dete of Death Month / Day / Year: January 28, 2001
3. Time of Death: 6:07 PM
4a. Facility Neme *(If not institution, give street end number)*: 6487 River Clyde Dr
4b. City, Town, or Location of Death: Highland
4c. County of Deeth: Howard

Funeral Director

5. Social Security Number: 220-38-4893
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 59 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Year)*: Dec 26, 1941
9. Birthplece *(Stete or Foreign Country)*: Idaho

To Be Completed by Funeral Director

Usuel Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Highland
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6487 River Clyde Dr
10f. Zip Code: 20777
10g. Citizen of Whet Country?: USA
11. Maritel Stetus: 1☐ Never Married 2☒ Merried 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces?: 1☒ Yes 2☐ No — If Yes, Give Yeer or Detes: 1960-1966
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* White
15. Decedent's Educetion *(Specify only highest grade completed)*: Elementery/Secondery (0-12); College (1-4or 5+): 2
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: National Accounting Manager
16b. Kind of Business/Industry: Minolta QMS
17. Fether's Neme *(First, Middle, Last)*: Herbert Gordon
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Eileen Madsen
19a. Informent's Neme/Reletionship *(Type, Print)*: Judith A. Gordon/Wife
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 6487 River Clyde Dr, Highland, MD 20777
20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, crematory or other piece)*: Fort Lincoln Cemetery
Dete: Feb 1
20c. Location - City or Town, State: Brentwood, MD
21. Signeture of Funerel Service Licensee: Alan J. Donnell
22. Neme end Address of Feciliby: Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave, Silver Spring, MD 20904

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Cause (Finel disease or condition resulting in deeth)
a. Metastatic Adenocarcinoma of Esophagus to Liver — Imonth
Due to (or es e consequence of):
Sequentially list conditions, if any, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medicel examiner? 1☐ Yes 2☒ No
26. Plece of Death *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*
27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, In my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner steted.
29b. Signeture end title of certifier: Nicholas Lee Rowe
29c. License number: D38509
29d. Dete signed *(Month, Dey, Year)*: January 31 2001
30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Nicholas Lee Rowe Associates 11065 Little Patuxent Pkwy Columbia MD 21044

State Registrar

31. Dete filed *(Month, Dey, Year)*: FEB 02 2001
32. Registrer's Signeture: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04432

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Christie Helene Golemo

2. Date of Death: Month JANUARY Day 24 Year 2001

3. Time of Death: 10:20 AM

4a. Facility Name (If not institution, give street and number): Doctors Community Hospital

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 219-82-2838

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 40 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): July 25, 1960

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Berwyn Heights

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8717 60th Avenue

10f. Zip Code: 20740

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Customer Service Representative

16b. Kind of Business/Industry: Sales & Printing

17. Father's Name (First, Middle, Last): Donald Eugene Brant, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Lucille J. Thomas

19a. Informant's Name/Reletionship (Type, Print): Lucille Brant/ Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7115 24th Place, Hyattsville, MD 20783

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Parklawn Memorial Park

Date: Jan 29 2001

20c. Location - City or Town, State: Rockville, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Hodgkin's Disease — 2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Sepsis, Respiratory failure, Renal failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes cese referred to medicel exeminer? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete and place, and due to the ceuse(s) and mannar steted.

29b. Signature and title of certifier: [signature] MD

29c. License number: D01852

29d. Date signed (Month, Day, Year): JANUARY 25 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): PAUL A. DEVORE MD 4203 Queensbury Rd Hyattsville MD 20781

State Registrar

31. Data filed (Month, Day, Year): JAN 29 2001

32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04433

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen Elizabeth Giuliano
2. Date of Death Month Day Year: January 28, 2001
3. Time of Death: 8:40 AM
4e. Facility Name *(If not institution, give street end number)*: 9902 Edward Avenue
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 217-36-8411
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: November 14, 1916
9. Birthplace *(State or Foreign Country)*: Washington, D.C.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9902 Edward Avenue
10f. Zip Code: 20814
10g. Citizen of What Country?: United States
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Supervisor
16b. Kind of Business/Industry: N.I.H.
17. Father's Name *(First, Middle, Last)*: Wilber Allison Leland
18. Mother's Name *(First, Middle, Maiden Surname)*: Susan Eva Butler
19a. Informant's Name/Relationship *(Type, Print)*: Judith C. Giuliano/ Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 119 Barnsfield Court Gaithersburg, Maryland 20878
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Montgomery Crematorium Inc.
Date: January 30, 2001
20c. Location - City or Town, State: Bethesda, Maryland
21. Signature of Funeral Service Licensee: [signature] M00335
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Mitral Regurgitation

Due to (or as a consequence of):
c. Endocarditis

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypertension
Pulmonary Hypertension

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] Lakshmi Sastry
29c. License number: D54867
29d. Date signed *(Month, Day, Year)*: January 29, 2001
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Lakshmi S. Sastry, M.D. 10215 Fernwood Road, #100 Bethesda, Maryland 20817-1106

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 01 2001
32. Registrar's Signature: [signature] Geneva G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Wilber Allison Leland Susan Ev

Judith C. Giuliano/ Daughter 119 Barnesfield Court Gaithersb

X January

Montgomery Crematorium Inc. 30, 2001

Robert A. Pumphrey Funeral F
Bethesda-Chevy Chase, Inc.,
M00335 Bethesda, Maryland 20814-350

Congestive Heart Failure

Mitral Regurgitation

Endocarditis

X

Mar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04434

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Arthur Gauss
2. Date of Death (Month, Day, Year): January 25, 2001
3. Time of Death: 1:11PM
4a. Facility Name *(If not institution, give street and number)*: Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 219-42-4695
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 94 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 8, 1906
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4503 Harling Lane
10f. Zip Code: 20814
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): ; College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Patent Examiner
16b. Kind of Business/Industry: U.S. Government

17. Father's Name *(First, Middle, Last)*: Herman Christian Gauss
18. Mother's Name *(First, Middle, Maiden Surname)*: Lena Mueller

19a. Informant's Name/Relationship *(Type, Print)*: Arthur Gauss, Jr./Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 890, Truro, Massachusetts 02666

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Montgomery Crematorium, Inc.
Date: Jan. 29 2001
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service licensee: Donald E. Leary. M00803
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for usa as the burial-transit

GAUSS, ARTHUR 01-25-2001 1:11 pm

10

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

		Approximete Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in death) a.	Respiratory arrest-	5mts
Due to (or as a consequence of): b.	Respiratory failure	1hr.
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last — Due to (or as a consequence of): c.	Aspiration Pneumonia.	3hrs.
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Malnourished. Depression COPD

23b. Did tobacco use contributa to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was en autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Was cese referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Piece of Deeth *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) end menner es stated. 2 [ ] **Medical Examiner:** On the besis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and menner stated.

29b. Signature and title of certifier: Raman R. Tuli
29c. License number: D19609
29d. Date signed *(Month, Dey, Year)*: 1-26-01

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): RAMAN R. TULI, MD — 10810 DARNESTOWN ROAD, SUITE 202 GAITHERSBERG, MD 20878

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 30 2001
32. Registrer's Signeture: Bonnie B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04435

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Louise H. Garziglia

2. Data of Death Month: January Day: 25 Year: 2001

3. Time of Death: 4:14PM

4a Facility Neme (If not institution, give street end number): Manor Care

4b. City, Town, or Location of Deeth: Chevy, Chase

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 510-14-4708

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Oct. 31, 1919

9. Birthplece (State or Foreign Country): Kansas

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: Montgomery

10c. City, Town or Location: Kensington

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3825 Denfeld Aveune

10f. Zip Code: 20895

10g. Citizen of Whet Country?: United States

11. Maritel Status: 1☐ Never Merried 2☒ Merried 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, Whita, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 4

16e. Decedent's Usuel Occupetion (Giva kind of work done duning most of working life. DO NOT use retired): Budget Analysis

16b. Kind of Business/Industry: Federal Goverment

17. Father's Neme (First, Middle, Last): John Honn

18. Mother's Neme (First, Middle, Maiden Surneme): Grace Miller

19a. Informent's Neme/Relationship (Type, Print): Bernard J. Garziglia / Husband

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 3825 Denfeld Aveune Kensington, MD 20895

20e. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other place): Chesapeake Crematory

Dete: Jan. 31, 2001

20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funerel Service Licensee: Irwin A. Moody

22. Name end Address of Fecility: Rapp Funeral And Cremation Service 933 Gist Aveune Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions that ceused the death. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert failure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediate Ceuse (Finel disease or condition resulting in deeth)

e. Pneumonia Asperation — 2 weeks

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediete ceusa. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lest

b. Dysphagia Due Parkinson Disease — 1 month

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying ceuse given in Part f.

23b. Did tobacco uae contribute to the cauee of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes cese referred to medicet examiner? 1☐ Yes 2☒ No

26. Piece of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Mannar of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Deta of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of tnjury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end piece, and due to the ceuse(s) end menner es stated. 2☐ **Medicel Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end piece, end due to the ceuse(s) and manner stated.

29b. Signeture and title of certifier: James Foster MD

29c. Licensa number: D04179

29d. Data signed (Month, Day, Year): January 29, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Dr. James Foster, M.D.; 5530 Wisconsin Ave., #925, Chevy Chase, Maryland 20815

State Registrar

31. Dete filed (Month, Dey, Year): JAN 31 2001

32. Registrer's Signeture: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

b

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

b

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04436

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Charles S. Garrison
2. Date of Death (Month, Day, Year): January 30, 2001
3. Time of Death: 11:58 PM
4a. Facility Name *(If not institution, give street and number)*: Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 218-38-9077
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 59 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov. 2, 1941
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Kensington Heights
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3115-1 UNiversity Blvd., West
10f. Zip Code: 20895
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1960-1963
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Heavy Machine Operator
16b. Kind of Business/Industry: Escavating
17. Father's Name *(First, Middle, Last)*: Earnest Garrison
18. Mother's Name *(First, Middle, Maiden Surname)*: Edith Morris
19a. Informant's Name/Relationship *(Type, Print)*: Kathy Garrison / Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3115-1 University Blvd., West, Kensington, MD 20895
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Rock Creek Cemetery — Date: 02/02/01
20c. Location - City or Town, State: Washington, DC
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Septic Shock

Due to (or as a consequence of):
b. Respiratory Failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Pneumonia.

Due to (or as a consequance of):
d. Diabetics Mellitus.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Cerebrovascular Accident

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Thomas V. Joseph
29c. License number: D47330
29d. Date signed *(Month, Day, Year)*: 1/31/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Thomas V. Joseph, 50 W. Edmonston Dr. Rockville. MD 20852

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 02 2001
32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Hines/Rinaldi Funeral Home
Charles Samuel Garrison
1/30/01 11:58 pm
5+1

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND: #9 mcg 2/5/01 AACO HEALTH DEPT

Certificate of Death

Reg. No 2001 04437

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Philip Pickering Gerrior, SR.

2. Date of Death (Month, Day, Year): January 29, 2001

3. Time of Death: 3:06PM

4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 218-26-6120

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 23, 1928

9. Birthplace (State or Foreign Country): ~~Married~~ MD

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1132 Bay Ridge Road

10f. Zip Code: 21403

10g. Citizen of Whet Country?: United States

11. Meritel Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Evar in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Detes: 1946 to 1951

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Reca - American Indien, Blеck, White, etc. Specify: white

15. Decedent's Education (Specify only highest greda completed)

Elementery/Secondary (0-12):

College (1-4or 5+): +1

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner/Operator

16b. Kind of Business/Industry: Nursery/Garden Center Landscape

17. Fether's Nema (First, Middle, Last): Vincent Francis Gerrior

18. Mother's Neme (First, Middle, Maiden Sumema): Laura Condon

19a. Informent's Name/Reletionship (Type, Print): Evelyn Jane Gerrior (wife)

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 1132 Bay Ridge Road Annapolis, Maryland 21403

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Remuvel from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece): Lakemont Memorial Gardens

Dete: 02/02/2001

20c. Location - City or Town, State: Davidsonville, MD

21. Signature of Funerel Servica Licensee: Beverly M. Barton

22. Name and Address of Feciility: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, Maryland 21401

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Final disease or condition resulting in deeth): e. myocardial infarction — immediate

Due to (or as e consequence of): b. hypertension — unknown

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in death) Lest

Due to (or es a consequenca of): c. Chronic renal insufficiency — unknown

Due to (or as a consequence of): d. status post renal transplant — 1989

Part II. **Other sfgnificant conditions** contributing to death but not resulting in the underlying cause given in Part I.

- dilated cardiomyopathy
- restrictive lung disease secondary to amyotrophic lateral sclerosis

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Ware eutopsy findings available prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Wes casa referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one): Hospitel: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residenca 6 [ ] Other (Specify)

27. Menner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, farm, straet, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physicfan:** To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) end menner es steted. 2 [ ] **Medical Examiner:** On the besis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end pleca, end due to the ceuse(s) end menner steted.

29b. Signature and title of certifier: MD

29c. License number: D44161

29d. Dete signed (Month, Dey, Year): 1/29/2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Patricia Czapp, MD 600 Ridgely Ave #120 Annapolis, MD 21401

State Registrar

31. Deta filed (Month, Day, Year): FEB 05 2001

32. Registrer's Signeture:

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

FEB 02 2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04438

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Sybil Frances Hucke
2. Date of Deeth — Month: January Dey: 24, Yeer: 2001
3. Time of Deeth: 1:45AM
4e. Feciility Name (If not institution, give street end number): Potomac Valley Nursing Home
4b. City, Town, or Location of Deeth: Rockville
4c. County of Deeth: Montgomery

Funeral Director

5. Sociel Security Number: 102-05-9045
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. lest birthday): 92 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): August 30, 1908
9. Birthplace (Stete or Foreign Country): New York

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: Montgomery
10c. City, Town or Location: Potomac
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 11705 Split Tree Circle
10f. Zip Code: 20854
10g. Citizen of What Country?: United States
11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: White
15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 11 — College (1-4or 5+): -
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Fether's Neme (First, Middle, Last): Not Available
18. Mother's Name (First, Middle, Maiden Surname): Not Available
19e. Informent's Neme/Relationship (Type, Print): Wayne Allan Hucke/ Son
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 11705 Split Tree Circle, Potomac, Maryland 20854
20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other place): Montgomery Crematorium, Inc.
Date: January 25, 2001
20c. Location - City or Town, State: Bethesda, Maryland
21. Signature of Funeral Service Licensee: M00689
22. Name end Address of Feciility: Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23. Pert I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

		Approximete Intervel Between Onset end Deeth
Immediate Ceuse (Final diseese or condition resulting in deeth) e.	Pneumonia	2 days
Due to (or es e consequence of):		
Sequentielly list conditions, if eny, leading to immediete ceuse. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Last b.	Congestive Heart Failure	
Due to (or es e consequence of):		
c.		
Due to (or es e consequence of):		
d.		

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: Dementia

23b. Did tobacco uee contribute to the cauee of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the besis of exemination end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end menner stated.

29b. Signature end title of certifier
29c. License number: D01120
29d. Date signed (Month, Dey, Yeer): January 25, 2001

30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): Walter E. Goozh, M.D. 1299 Lamberton Drive, Silver Spring, Maryland 20902-2293

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

10

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 29 2001
32. Registrer's Signature: Donna B. Sparks.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04439

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Carolyn Mary Holloran
2. Date of Death (Month, Day, Year): January 26, 2001
3. Time of Death: 1:30AM
4a. Facility Name (If not institution, give street and number): Citizen's Nursing Home
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 579-09-2964
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 5, 1913
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Germantown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11309 Willowdale Drive
10f. Zip Code: 20876
10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Banker
16b. Kind of Business/Industry: Banking

17. Father's Name (First, Middle, Last): Thomas Holloran
18. Mother's Name (First, Middle, Maiden Surname): Edna Eber

19a. Informant's Name/Relationship (Type, Print): Cynthia D. Page/Cousin
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11309 Willowdale Drive, Germantown, MD 20876

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc. | Date: Jan 27 2001
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: David E. Perry M00803
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Hypertensive Cardiovascular Disease — 5 Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert A. Kaufman
29c. License number: D13971
29d. Date signed (Month, Day, Year): January 26, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Robert Kaufman, M.D. 300 West 9th Street, Frederick, Maryland 21701

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001
32. Registrar's Signature: Donna D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04440

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lora E. Hines
2. Date of Death Month Day Year: January 27, 2001
3. Time of Death: 12:11AM
4a. Facility Name *(If not institution, give street and number)*: Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 220-28-7107
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 71 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Apr. 15, 1929
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5672 Crabapple Drive
10f. Zip Code: 21703
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Book Binder
16b. Kind of Business/Industry: Printing Company

17. Father's Name *(First, Middle, Last)*: Clifford C. Pearson
18. Mother's Name *(First, Middle, Maiden Surname)*: Lena Cordelia Posey

19a. Informant's Name/Relationship *(Type, Print)*: Buford L. Hines/Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5672 Crabapple Drive, Frederick, Maryland 21703

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parklawn Memorial Park — Date: Jan 31 2001
20c. Location - City or Town, State: Rockville, Maryland

21. Signature of Funeral Service Licensee: David E. Perry. M00803
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Aspiration Pneumonia	5 Days
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Glioblastoma Multiforme, Right Occipital	6 Weeks
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension, Diabetes Mellitus, Secondary to Cortico-steroids, Pancytopenia Post-Op Etiology

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D21944
29d. Date signed *(Month, Day, Year)*: January 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James S. Grissom, M.D. 300 West 9th Street, Frederick, Maryland 21701

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 01 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04441

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Elbert Henning

2. Date of Death (Month, Day, Year): January 24, 2001

3. Time of Death: 10:00AM

4a. Facility Name (If not institution, give street and number): Rockville Nursing Home

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-34-9499

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 26, 1925

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10e. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 15712 White Rock Road

10f. Zip Code: 20878

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Stockroom Supervisor

16b. Kind of Business/Industry: Goodwill Industries

17. Father's Name (First, Middle, Last): Charles Wesley Henning

18. Mother's Name (First, Middle, Maiden Surname): Drusie P. Poling

19a. Informant's Name/Relationship (Type, Print): Barbara H. Dobson/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15712 White Rock Road, Gaithersburg, Maryland 20878

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc.

Date: January 25, 2001

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: Ray Fuhrey M00198

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Pneumonia — Days

Due to (or as a consequence of):

b. Chronic Obstructive Pulmonary Disease- Asthma — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Arteriosclerotic Heart Disease — Years

Due to (or as a consequence of):

d. Cerebral Palsey

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Frauke Westphal M.D.

29c. License number: D0019785

29d. Date signed (Month, Day, Year): January 25th 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Frauke Westphal, M.D. 809 Veirs Mill Road, Rockville, Maryland 20851

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #24a, 2/2/2001, BMW, Montg.Co.

Certificate of Death

Reg. No. 2001 04442

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
GINGER	HARRIS		JANUARY 20, 2001	5:30 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SHADY GROVE ADVENTIST HOSPITAL	ROCKVILLE	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-94-3288	1☐ M 2☒ F	21 Yrs.			Sept. 22, 1979	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Germantown	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
18862 Bent Willow Circle, #1042	20874	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2 yrs	Student	Education

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Nathaniel G. Harris , IV	Joan M. Mercer

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Joan M. Browne (Mother)	18862 Bent Willow Cir, #1042, Germantown, MD 20874

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Md. Nat'l Mem. Park	1/26/01	Laurel, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
George R. Snowden	SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. INTRACEREBRAL & INTRAVENTRICULAR HEMORRHAGE	24 hrs
Due to (or as a consequence of):	b. ISCHEMIC CEREBRAL VASCULAR ACCIDENT	2 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. AORTIC VALVE VEGETATION	?
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown	1☒ Yes 2☐ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	MD	D 56652	JANUARY 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATTHEW POFFENROTH, MD 809 VIERS MILL RD, ROCKVILLE, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 02 2001	G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

6

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #8 PER INFORMANT G792 2-27-01 WC

Certificate of Death

Reg. No. 2001 04443

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Michael Irving Halper
2. Data of Death Month Day Year: January 26, 2001
3. Tima of Death: 12:18 PM
4a. Facility Nama *(If not institution, giva street and number)*: Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 090-36-7848
6. Sax: 1☒ M 2☐ F
7. Aga *(In yrs. last birthday)*: 54 Yrs. — If Under 1 Yaar: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: ~~10-8-1946~~ 10/18
9. Birthplace *(State or Foraign Country)*: NY

Usual Residence of Decedent

10a. Stata: MD
10b. County: Frederick
10c. City, Town or Location: Walkersville
10d. Insida City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 8783 Inspiration Ct.
10f. Zip Coda: 21793
10g. Citizan of What Country?: USA
11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*
14. Race - American Indian, Black, Whita, atc. *Specify:* WHITE
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 5+
16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT use retired)*: Attorney
16b. Kind of Business/Industry: Law
17. Fathar's Name *(First, Middla, Last)*: William W. Halper
18. Mothar's Nama *(First, Middle, Maiden Sumama)*: Esther Kagan
19a. Informant's Name/Relationship *(Type, Print)*: Marvene Halper Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8783 Inspiration Ct, Walkersville, MD 21793
20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Ramoval from Stata 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Nama of cematery, cramatory or othar place)*: GreenWood Cemetery
Date: 1/28/01
20c. Location - City or Town, Stata: Atlanta, GA
21. Signature of Funeral Service Licensee
22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION 1091 Rockville Pike, Rockville, MD 20852

Physician /Medical Examiner

23a. Part I. Entar the diseasa, or complications that causad tha death. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one ceuse on aach line.

Approximate Intarval Batween Onsat and Death

Immediata Cause (Final disaasa or condition resulting in death)
a. R pneumonia — Dua to (or as a consequance of):
Sequentially list conditions, if any, leading to immadiata causa. Enter Undarlying Cause (Disease or injury that initiated avants rasulting in death) Last
b. — Dua to (or as a consequence of):
c. — Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

Myotonic dystrophy
Ventricular Tachycardia 2° to Myotonic Dystrophy

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wera autopsy findings available prior to completion of causa of death? 1☐ Yas 2☐ No

25. Was cesa rafarrad to medicel axaminar? 1☐ Yas 2☒ No

26. Place of Death *(Check only ona)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Othar: 4☐ Nursing Homa 5☐ Rasidence 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28a. Place of Injury - At homa, farm, streat, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Cartifier *(Check only one)*: 1☒ **Certifying Physician**: To tha best of my knowledga, death occurred at tha time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar statad.

29b. Signatura and titla of cartifiar
29c. Licansa number: D26516
29d. Data signed *(Month, Day, Year)*: JAN 26 2001

30. Nama and address of parson who complatad causa of daath (Itam 23a) (Type, Print): Allen J. Gisel 1475 TANEY AVE FRED MD 21702

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 29 2001
32. Registrar's Signatura: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04444

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANNA LOIS HAGA

2. Data of Death (Month, Dey, Year): JANUARY 31, 2001

3. Time of Deeth: 6:45 PM

4a. Feclity Name (If not institution, giva street end number): BROOKE GROVE NURSING HOME

4b. City, Town, or Location of Deeth: OLNEY

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 218-10-2229

8. Sex: 1☐ M 2☒ F

7. Aga (In yrs. last birthdey): 86 Yrs.

If Undar 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 2, 1914

9. Birthplace (Stete or Foreign Country): Virginia

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 17816 Cashell Road

10f. Zip Coda: 20853

10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Merried 3☒ Widowad 4☐ Divorced

12. Wes Decedant Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Amarican Indian, Bleck, Whita, atc. Specify: White

15. Decedant's Education (Spacify only highast grade completed): Elementery/Secondary (0-12): 8; College (1-4or 5+): 0

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): William R. Cook

18. Mothar's Nama (First, Middle, Meiden Surname): Rosa Crouse

19a. Informant's Name/Relationship (Type, Print): Joycelene F. Gregg / Daughter

19b. Mailing Address (Street and Number or Rural Route Numbar, City or Town, Stete, Zip Coda): 17816 Cashell Road, Rockville, Maryland 20853

20a. Method ot Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Ramovel from Stete 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cematary, cremetory or other piece): Laytonsville Cemetery

Deta: 2/3/01

20c. Location - City or Town, State: Laytonsville, Md.

21. Signature of Funaral Service Licensae: Roy W. Barber

22. Nema and Address of Facility: Muriel H. Barber Funeral Home, P.O. Box 5038, Laytonsville, Maryland 20882

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or haart failure. List only ona cause on each lina.

Approximate Intarval Betwaan Onsat and Death

Immediate Cause (Final disease or condition resulting in deeth)
a. CONGESTIVE HEART FAILURE — 2 yrs.

Due to (or es e consequence of):
b. CORONARY ARTERY DISEASE — 10 yrs.

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet Initieted avants resulting in deeth) Last

Due to (or as e consequence ot):
c. BILATERAL LEG EDEMA — 6 yrs.

Due fo (or es a consaquance of):
d.

Part II. **Othar significent conditions** contributing to deeth but not rasulting in the underlying cause given in Part I.

23b. Did tobacco uae contributa to tha cauae of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed? 1☐ Yas 2☑ No

24b. Wera autopsy findings available prior to completion of cause ot death? 1☐ Yes 2☐ No

25. Was cesa rafarred to madical axaminar? 1☐ Yes 2☑ No

26. Placa of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Othar: 4☑ Nursing Homa 5☐ Rasidence 6☐ Other (Specify)

27. Manner of Deeth: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, tarm, street, factory, office building, etc. (Spacify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To tha bast ot my knowledge, death occurred at the tima, data end place, end due to the ceuse(s) end mannar as statad. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, daath occurred at tha tima, data and placa, and due to the cause(a) and manner stated.

29b. Signature and title of certifier: M. Wajeed Khan MD

29c. License number: D52817

29d. Date signed (Month, Dey, Year): February 1, 2001

30. Name and addrass of person who complated ceuse ot death (Item 23e) (Type, Print): M. WAJEED KHAN, M.D. 12016 GEORGIA AVE., WHEATON, MARYLAND 20902

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Data filed (Month, Day, Year): FEB 02 2001

32. Registrer's Signature: Diane G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04445

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Julia Mae Horner

2. Date of Death: Month January Dey 30, Year 2001

3. Time of Death: 10:20 PM

4a. Facility Name (If not institution, give street and number): 3102 Queens Castle Ct.

4b. City, Town, or Location of Death: Street

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 215-24-1201

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): Jan. 2, 1916

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Street

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 3102 Queens Castle Ct.

10f. Zip Code: 21154

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Evar in U.S. Armad Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedant of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highast grede completed): Elementery/Secondery (0-12): 10 College (1-4or 5+):

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Fether's Neme (First, Middle, Last): Edward Lee Whitlock

18. Mother's Name (First, Middle, Malden Surnema): Alice (u/k) Dillard

19a. Informent's Name/Reletionship (Type, Print): Elsie M. Smith / Daughter

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): [redacted] 3102 Queens Castle Ct., Street, MD 21154

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetary, cremetory or other piece): Bel Air Memorial Gardens Date: 2-2-01

20c. Location - City or Town, Stete: Bel Air, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not entar tha mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

		Approximete Intervel Between Onset end Death
Immediate Ceuse (Finel disease or condition resulting in deeth) e.	Congestive Heart Failure	Months
Due to (or es e consequence of): b.	Ischemic Heart Disease	Years
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet Initieted events resulting in death) Last — Due to (or es e consequence of): c.	Diabetes Mellitus	Years
Dua to (or es a consequence of): d.	ad C.V.A.	Years

Part II. **Other elgnificant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetic Nephropathy

Peptic ulcer Disease

23b. **Did tobacco uee contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physicien**: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to the ceuse(s) end manner stated.

29b. Signature and title of certifier: Perfecto C. Valarao M.D.

29c. Licansa number: D0016389

29d. Date signed (Month, Day, Yeer): January 31, 2001

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print): PERFECTO C. VALARAO, M.D. 1716 HARFORD RD FALLSTON MD 21047

State Registrar

31. Data filed (Month, Day, Yeer): FEB 2 2001

32. Registrer's Signature: Jennifer G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Maryland Department of Health end Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours efter deeth.
To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the buriel-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 04446

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GEORGE KENNETH HAGGERTY SR.

2. Date of Death Month Dey Yaer: February 2 2001

3. Time of Death: 10:12pm

4a Facility Name *(If not institution, give street and number)*: 155 Basil Ave.

4b. City, Town, or Location of Death: Chesapeake City

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 219-36-0333

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 68 Yrs.

If Under 1 Yeer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Yeer)*: Apr 8 1932

9. Birthplace *(Stete or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. Stete: MD

10b. County: Cecil

10c. City, Town or Location: Earleville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2199 Crystal Beach Rd.

10f. Zip Code: 21919

10g. Citizen of Whet Country?: U.S.A.

11. Maritel Status: 1☐ Never Merried 2☐ Married 3☐ Widowed 4☒ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Bleck, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 / College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Heavy Equipment operator

16b. Kind of Businass/Industry: Maryland State Highway Adm.

17. Father's Nema *(First, Middle, Last)*: John R. Haggerty

18. Mother's Nama *(First, Middle, Maiden Surname)*: Annie Husfelt

19a. Informent's Neme/Relationship *(Type, Print)*: George K. Haggerty Jr (son)

19b. Mailing Addrass *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 12 Cayots Corner Rd. Chesapeake City MD 21915

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cemetary, crematory or other piece)*: St. Paul's Cemetery

Dete: 2/6/01

20c. Location - City or Town, Stete: Earleville, MD.

21. Signature of Funeral Service Licensee: M00510

22. Name end Address of Facility: Galena Funeral Home of Stephen Schaech 118 West Cross St. Galena, MD. 21635

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immedieta Cause (Final disease or condition resulting in death)

a. End stage Congestive Heart Failure — 2yr

Due to (or as e consequence of):

b. End stage Diabetic Renal Failure — 2yr

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Colon Cancer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residance 6☒ Other *(Specify)*: Sisters Home

27. Menner of Deeth: 1☒ Neturel 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: Barbara A Parey MD

29c. License number: 025915

29d. Date signed *(Month, Day, Year)*: 2-5-01

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print): Barbara A. Parey MD Box 670 Cecilton MD 21913

State Registrar

31. Dete filed *(Month, Day, Year)*: FEB 05 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04447

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Arthur D. Heath, Sr.

2. Date of Death (Month, Day, Year): January 31, 2001

3. Time of Death: 1:45 A.M.

4a. Facility Name (If not institution, give street and number): 3656 7th Avenue

4b. City, Town, or Location of Death: Edgewater

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 578-05-5817

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 28, 1916

9. Birthplace (State or Foreign Country): Vermont

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Edgewater

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3656 7th Avenue

10f. Zip Code: 21037

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Charles F. Heath

18. Mother's Name (First, Middle, Maiden Surname): Kate Story

19a. Informant's Name/Relationship (Type, Print): Mary E. Heath/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3656 7th Avenue Edgewater, Maryland 21037

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Lakemont Meml. Gardens

Date: 2-3-01

20c. Location - City or Town, State: Davidsonville, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Cholangiocarcinoma	4 months
Due to (or as a consequence of):		
b.	Coronary Artery Disease	10 y
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Arterial Obstructive Disease	10 y
Due to (or as a consequence of): d.	Diabetes Mellitus	10 y

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D31997

29d. Date signed (Month, Day, Year): 02/01/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANDREW GORDON MD 2003 Medical Pkwy Ste 100 ANNAPOLIS, MD 21401

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04448

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RAYMOND W. HEATH

2. Date of Death (Month, Day, Year): JAN. 26 2001

3. Time of Death: 2:15 pm

4a. Facility Name *(If not institution, give street and number)*: GENESIS ELDER CARE @ SPA CREEK

4b. City, Town, or Location of Death: ANNAPOLIS

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 214-52-0905

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 52 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JAN. 23 1949

9. Birthplace *(State or Foreign Country)*: maryland

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: QUEEN ANNE

10c. City, Town or Location: GRASONVILLE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 5108 MAIN STREET

10f. Zip Code: 21638

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1968-70

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: DISPATCHER

16b. Kind of Business/Industry: US NAVAL ACADEMY

17. Father's Name *(First, Middle, Last)*: OSCAR HEATH

18. Mother's Name *(First, Middle, Maiden Surname)*: SELENA TURNER

19a. Informant's Name/Relationship *(Type, Print)*: ARLENNA HEATH (WIFE)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5108 MAIN ST. GRASONVILLE, MD. 21638

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: METRO CREMATORY

Date: 2/1/01

20c. Location - City or Town, State: BALTIMORE, MD.

21. Signature of Funeral Service Licensee: Larry D. Reese #000483

22. Name and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Lymphoma — 6M

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D32036

29d. Date signed *(Month, Day, Year)*: 1/29/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gary F. Sprake 2108 N. Point Drive Charlotte MO 21617

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 30 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04449

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert Huebner

2. Data of Death — Month: Jan. Day: 27, Year: 2001

3. Time of Death: 7:30 pm

4a. Facility Name *(If not institution, give street and number)*: 462 Maryleborn Road

4b. City, Town, or Location of Death: Severna Park

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 391-24-0946

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: June 21, 1930

9. Birthplace *(State or Foreign Country)*: Wisconsin

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Severna Park

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 462 Maryleborn Road

10f. Zip Code: 21146

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: 1951-1982

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4 or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Colonel in U.S. Army

16b. Kind of Business/Industry: Military

17. Father's Name *(First, Middle, Last)*: William Huebner

18. Mother's Name *(First, Middle, Maiden Surname)*: Agnes Stoach

19a. Informant's Name/Relationship *(Type, Print)*: Maxine M. Huebner/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 462 Maryleborn Road Severna Park, MD 21146

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory

Date: Jan. 31 2001

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: R C Barranco

22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Adenocarcinoma of the Prostate, Metastatic and — > 2 years

Due to (or as a consequence of):

b. Hormone Refractory

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Deep Vein Thrombosis of Lower Extremity

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☑No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☑Residence 6☐Other *(Specify)*

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R C Barranco

29c. License number: D42979

29d. Date signed *(Month, Day, Year)*: January 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 401 North Broadway, BALTIMORE MD 21231 Michael Carducci, MD

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 30 2001

32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

mcg Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Amend Items#6,7,11,12 perFHG792 2/16/2001 EW
Amended Item#31 perDVRG792 2/16/2001 EW

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04450

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Maria Lea Isnard
2. Date of Death (Month, Day, Year): January 27-01
3. Time of Death: 4:40
4a. Facility Name (If not institution, give street and number): Shore Nursing Home
4b. City, Town, or Location of Death: Denton
4c. County of Death:

Funeral Director

5. Social Security Number: 221-78-2579
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 67 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 6-10-1933
9. Birthplace (State or Foreign Country): GonalvesHaiti

Usual Residence of Decedent

10a. State: Delaware
10b. County:
10c. City, Town or Location: Seaford
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4 PLEASANT St.
10f. Zip Code: 19973
10g. Citizen of What Country?: Haiti

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Haitian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Factory
16b. Kind of Business/Industry: TOWNSEND Poultry

17. Father's Name (First, Middle, Last): Altus Mentus
18. Mother's Name (First, Middle, Maiden Surname): Belzina Also

19a. Informant's Name/Relationship (Type, Print): Nonfacial A. Isnard husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4 Pleasant St. Seaford Delaware 19973

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Odd Fellows — Date: 2-3-01
20c. Location - City or Town, State: Seaford Delaware

21. Signature of Funeral Service Licensee: Clarence E. Young
22. Name and Address of Facility: Youngs Funeral Home 308 N. Front St. Seaford Delaware 19973

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hepatic encephalopathy
Due to (or as a consequence of):
b. Cirrhosis of liver

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
acute renal failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Karen Moffett MD
29c. License number: D51639
29d. Date signed (Month, Day, Year): 1-27-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Karen Elizabeth Moffett Shore Nursing Home Denton Md

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001
32. Registrar's Signature: Barbara D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04451

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: SAMUEL EARL IRELAND SR.

2. Dete of Deeth Month / Dey / Yeer: February 1, 2001

3. Time of Deeth: 2140

4e Feciility Nema *(If not institution, give street end number)*: Kent & Queen Anne's Hospital, Inc.

4b. City, Town, or Location of Death: Chestertown

4c. County of Deeth: Kent

Funeral Director

5. Social Security Number: 216-18-2939

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. lest birthdey)*: 77 Yrs. — If Under 1 Yaar: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Deta of Birth *(Month, Day, Year)*: Jan 5, 1924

9. Birthplace *(Stete or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. Stete: MD

10b. County: Kent

10c. City, Town or Location: Chestertown

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street end Number: 22238 Tolchester Beach Rd.

10f. Zip Code: 21620

10g. Citizan of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Merried 2☒ Merried 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Yeer or Detes: 1944 – 1945

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2

16e. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Conductor

16b. Kind of Business/Industry: Railroad

17. Fethar's Name *(First, Middle, Last)*: Marion Milton Ireland

18. Mother's Name *(First, Middle, Maiden Sumeme)*: Nellie Lewis Jacobs

19e. Informent's Neme/Reletionship *(Type, Print)*: Ronald Ireland (son)

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 1731 Shanwick Court Forest Hill, MD. 21050

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: St. Paul's Cemetery

Dete: 2/5/01

20c. Location - City or Town, State: Chestertown, MD.

21. Signeture of Funeral Service Licensee: M00510

22. Neme and Address of Feciility: Galena Funeral Home of Stephen Schaech 118 West Cross St. Galena, MD. 21635

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory arrast, shock, or heart feilure. List only one cause on eech line.

Approximate Intervel Between Onset end Death

Immediate Cause (Final disease or condition resulting in deeth)
e. Metastatic Non-small cell lung cancer — 8 months

Due to (or es e consequence of):

Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events rasulting in death) Last
b.

Due to (or es a consequence of):
c.

Dua to (or as a consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Pert I.: ASCVD

23b. Did tobecco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yas 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigetion 6☐ Could not be detarmined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Steta)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) and menner steted.

29b. Signature and title of certifier

29c. License number: D 36054

29d. Date signed *(Month, Day, Year)*: February 2, 2001

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print): Patrick J. Shanahan MD 120 Speer Rd. Chestertown, MD. 21620

State Registrar

31. Data filed *(Month, Day, Year)*: FEB 05 2001

32. Registrar's Signatura

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the deeth certificete be executed within 24 hours after deeth.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04452

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Henry R. Ingle, Sr.

2. Date of Death Month / Day / Year: January 27, 2001

3. Time of Death: 9:30 P.M.

4a. Facility Name *(If not institution, give street end number)*: Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 214-28-4018

6. Sex: 1 X M 2 ☐ F

7. Age *(In yrs. last birthday)*: 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 16, 1932

9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1 ☐ Yes 2 X No

10e. Street and Number: 206 First Street

10f. Zip Code: 21401

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 ☐ No If Yes, Give Year or Dates: 1951-56

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 10th; College (1-4or 5+):

16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use ratired)*: Welder

16b. Kind of Business/Industry: Aerospace

17. Fathar's Name *(First, Middle, Last)*: Clarence Ingle

18. Mother's Nama *(First, Middle, Maiden Sumame)*: Euna Corn

19a. Informant's Name/Raletionship *(Type, Print)*: Patricia H. Ingle/ Wife

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 206 First Street Annapolis, MD 21401

20a. Method of Disposition: 1 XX Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, crematory or other piece)*: Ft. Lincoln Cemetery

Date: 1-31-01

20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name end Address of Facility: George P. Kalas Funeral Home
2973 Solomons Island Rd. Edgewater, MD 21037

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on aach lina.

Approximete Intarval Batween Onset end Death

Immediete Ceuse (Final diseesa or condition resulting in daath)

e. Chronic Obstructive Pulmonary Disease — 2yr

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediate causa. Entar Underlying Ceuse (Diseese or injury thet initieted events resulting in death) Lest

b. ____

Due to (or es a consequence of):

c. ____

Due to (or es e consequence of):

d. ____

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was en autopsy performed? 1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Wes case refarred to medicel examinar? 1 ☐ Yes 2 ☐ No

26. Place of Death *(Chack only ona)*: Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Homa 5 ☐ Residance 6 ☐ Othar *(Specify)*

27. Menner of Deeth: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicida 5 ☐ Pending investigetion 6 ☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, data and place, end dua to the ceusa(s) and menner es stated. 2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and dua to tha causa(s) end mennar steted.

29b. Signeture and title of certifier: ▶ [signature]

29c. License number: D32036

29d. Date signed *(Month, Dey, Year)*: 1/28/2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Gary J Sprouse 2108 Di Donato Drive Chula, MD 21619

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 30 2001

32. Registrer's Signeture: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, paga 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04453

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Jennings, Harold

Physician /Medical Examiner

1. Decedent's Nama *(First, Middla, Last)*: Harold Kenneth Jennings
2. Dete of Deeth Month Day Yaer: January 31 2001
3. Tima of Death: 0320
4a Facility Nama *(If not institution, give street end number)*: Upper Chesapeake Medical Center
4b. City, Town, or Location of Death: Bel Air
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 212-30-7458
6. Sax: 1☒M 2☐F
7. Aga *(In yrs. last birthdey)*: 68 Yrs. — If Under 1 Yaer: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Yaer)*: Aug. 9, 1932
9. Birthplace *(Stata or Foreign Country)*: Maryland

Usual Rasidance of Decedant

10a. Steta: Maryland
10b. County: Harford
10c. City, Town or Location: Bel Air
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 119 Courtland Place
10f. Zip Coda: 21014
10g. Citizen of What Country?: USA
11. Marital Status: 1☐Navar Marriad 2☒Married 3☐Widowed 4☐Divorced
12. Was Dacedant Evar in U.S. Armed Forcas? 1☒Yas 2☐No If Yes, Giva Yeer or Detes:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxicen, Puarto Rican, atc.) 1☐Yas 2☒No *Specify:*
14. Race - Amaricen Indian, Black, Whita, atc. *Specify:* White
15. Decedant's Education *(Specify only highast grada complated)*: Elamentary/Secondery (0-12): 12 — Collega (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work done duning most of working life. DO NOT usa ratired)*: Owner/Operator
16b. Kind of Business/Industry: Car Repair
17. Fathar's Nama *(First, Middla, Last)*: Allen Fonce Jennings
18. Mother's Neme *(First, Middla, Maidan Sumama)*: Irene (UNK) Smoot
19a. Informant's Name/Ralationship *(Type, Print)*: Deloris L. Jennings
19b. Mailing Addrass *(Straat end Number or Rural Route Number, City or Town, Stata, Zip Coda)*: 119 Courtland Place, Bel Air, MD 21014
20a. Mathod of Disposition: 1☒Burial 2☐Cremetion 3☐Removal from Stete 4☐Donation 5☐Othar *(Specify)*
20b. Place of Disposition *(Neme of cematary, crametory or othar place)*: Mt. Zion U.M. Cemetery
Date: 2/2/01
20c. Location - City or Town, Stata: Bel Air, MD
21. Signatura of Funeral Sarvice Licensee: Stephen A. Krug
22. Nama and Address of Facility: McComas Funeral Home, P.A. 50 West Broadway Street, Bel Air, MD 21014

Physician /Medical Examiner

23a. Part1. Entar the diseese, or complications that caused the daath. Do not enter the mode of dying, such es cardiec or respiratory arrast, shock, or haart tailura. List only one cause on aach tine. — Approximate Interval Between Onsat and Death

Immediate Cause (Finel disaese or condition rasulting in daath)
a. HYPOXIC BRAIN INJURY
Dua to (or as a consequance of):
b. CARDIOPULMONARY ARREST

Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Ceuse (Disease or Injury thet initiated events rasulting in death) Last
Dua to (or as a consequance of):
c.
Dua to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to daath but not rasulting in tha undarlying causa given in Part I.

23b. Did tobacco uae contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Wes en autopsy performed? 1☐Yas 2☒No

24b. Wara autopsy findings availeble prior to complation of causa of deeth? 1☐Yes 2☐No

25. Was casa raferred to medicel examinar? 1☐Yas 2☒No

26. Place of Death *(Check only ona)*: Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA — Other: 4☐Nursing Homa 5☐Rasidence 6☐Othar *(Specify)*

27. Mannar of Death: 1☒Natural 2☐Accident 3☐Suicida 4☐Homicida 5☐Panding invastigation 6☐Could not be datarmined

28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐Yas 2☐No
28d. Dascribe how injury occurred
28a. Piece of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifier *(Check only one)*: 1☒**Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to the ceuse(s) and mennar as stated. 2☐**Medical Examiner:** On the basis of examination and/or invastigation, in my opinion, daath occurred at tha time, date end piece, and due to tha causa(s) end mennar stated.

29b. Signature and title of certifier: patricia gurry md
29c. License number: D26344
29d. Data signed *(Month, Day, Yaer)*: 1-31-01

30. Name and eddress of person who completed causa of death (Item 23a) (Type, Print): PATRICIA GURRY, MD - UPPER CHESAPEAKE MEDICAL CENTER, BELAIR, MD

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 2 2001
32. Registrar's Signatura: Deanna G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04454

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Carroll Albert Janney

2. Date of Death (Month, Day, Year): January 27 2001

3. Time of Death: 1017

4a. Facility Name (If not institution, give street and number): Union Hospital

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 216-10-1084

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): NOV 9, 1912

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Elkton

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10a. Street and Number: 3683 Telegraph Road

10f. Zip Code: 21921

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter/Millwright

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Albert Blake Janney

18. Mother's Name (First, Middle, Maiden Surname): Ethel Miller

19e. Interment's Name/Relationship (Type, Print): Madeline C. Janney/Wife

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 3683 Telegraph Road, Elkton, Maryland 21921

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Oxford Cemetery

Date: 1/30/01

20c. Location - City or Town, State: Oxford, Pennsylvania

21. Signature of Funeral Service Licensee: ▶ Donald S. Hicks

22. Name and Address of Facility: Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the death. Do not enter the mode ot dying, such as cardiac or respiratory errest, shock, or heert teilure. List only one ceuse on eech tine.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hyperkalemia — ? <2 wks.

Due to (or es e consequenca ot):

b. Renal Insufficiency — 6 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence ot):

c. Sick Sinus Syndrome — 6 months

Due to (or as a consequence of):

d. Atrial fibrillation - Slow Response — 2 weeks

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings eveileble prior to completion of cause ot death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medicat exeminer? 1 [ ] Yes 2 [✓] No

26. Piece ot Deeth (Check only one) Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Menner ot Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Dete ot Injury (Month, Dey Year)

28b. Time ot Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1 [✓] **Certifying Physician:** To the best ot my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2 [ ] **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, death occurred et the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Vivek Varma, MD

29c. License number: D35832

29d. Date signed (Month, Dey, Year): JAN 27, 2001

30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print): VIVEK VARMA, MD 206 SOUTH STREET, SUITE C, ELKTON, MD 21921

State Registrar

31. Date filed (Month, Dey, Year): JAN 31 2001

32. Registrer's Signature: ▶ Jeanne D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04455

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Arthur John Jackson
2. Date of Death Month: February Day: 1 Year: 2001
3. Time of Death: 1500 P
4a. Facility Name (If not institution, give street and number): Laurelwood Care Center
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 219-28-5894
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN 30, 1927
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Elkton
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 32 Muddy Lane
10f. Zip Code: 21921
10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: State Government

17. Father's Name (First, Middle, Last): John Jackson
18. Mother's Name (First, Middle, Maiden Surname): Goldie Mae Eaton

19a. Informant's Name/Relationship (Type, Print): Clarence Jackson/Brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 150 East Main Street, Apartment 306, Elkton, MD 21921

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): R.A. Ferris & Co. Inc.
Date: 2/2/01
20c. Location - City or Town, State: West Chester, PA

21. Signature of Funeral Service Licensee: John B. Hicks
22. Name and Address of Facility: Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Carcinoma of lung — 2 months
Due to (or as a consequence of):
b. with Brain metastasis — 2 months
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Severe peripheral Vascular disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Jayantilal C. Patel MD
29c. License number: D22307
29d. Date signed (Month, Day, Year): 02/05/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAYANTILAL C. PATEL MD 123 Emgerly Ave, Elkton MD 21921

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001
32. Registrar's Signature: Jennie B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND# 12 2/5/01 AACO HEALTH cmh

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04456

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Wendall Johnson
2. Date of Death: Month January Day 30 Year 2001
3. Time of Death: 4:59 am
4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 070-12-0530
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 80 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jul 17, 1920
9. Birthplace (State or Foreign Country): Maine

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Severna Park
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 802 Teakwood Drive
10f. Zip Code: 21146
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? ☒ Yes ~~2☐ No~~ If Yes, Give Year or Dates: 1940-1962
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Security Advisor
16b. Kind of Business/Industry: Federal Government
17. Father's Name (First, Middle, Last): Julius Johnson
18. Mother's Name (First, Middle, Maiden Surname): Gladys Sutherland
19a. Informant's Name/Relationship (Type, Print): Jennifer Johnson/Granddaughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 802 Teakwood Drive Severna Park, MD 21146
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify):
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory
Date: Jan 31 2001
20c. Location - City or Town, State: Baltimore, MD
21. Signature of Funeral Service Licensee: James E Parsons
22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Bradycardia — Minutes
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
GI Bleed
Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)
27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year):
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred:
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify):
28f. Location (Street and Number or Rural Route Number, City or Town, State):

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: DM35494
29d. Date signed (Month, Day, Year): 1/30/2001
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Steven Resnick Anne Arundel Medical Center

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: [signature] D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04457

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RUTH JACKSON

2. Date of Death Month Dey Yeer: JAN. 28 2001

3. Time of Death: 6:40 am

4a Facility Name *(If not institution, give street and number)*: 130 HEARNE RD. APT. 601

4b. City, Town, or Location of Death: ANNAPOLIS

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 219-22-1205

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 72 Yrs.

If Under 1 Yaar: Months / Days

If Undar 24 Hrs.: Hours / Min.

8. Dale of Birth *(Month, Dey, Year)*: JULY 12 1928

9. Birthpleca *(Stete or Foreign Country)*: MARYLAND

Usuel Residence of Decedent

10a. Stete: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: ANNAPOLIS

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 130 HEARNE RD. APT. 601

10f. Zip Code: 21401

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 11th; College (1-4or 5+): 0

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: FACTORY WORKER

16b. Kind of Business/Industry: ANDREA FANTASY

17. Fether's Name *(First, Middle, Last)*: ARCHIE THOMPSON

18. Mothar's Nama *(First, Middle, Maiden Surneme)*: RUTH K. JENKINS

19e. Informent's Neme/Reletionship *(Type, Print)*: MYRNA C. LONESOME (DAUGHTER)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 130 HEARNE RD. APT. 601 ANNAPOLIS, MD. 21401

20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: METRO CREMATORY

Date: 1/30/01

20c. Location - City or Town, Stete: BALTIMORE, MD.

21. Signetura of Funerel Service Licensee: ▶ Lavoy D. Reese M00483

22. Name end Address of Fecility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert tailure. List only one cause on eech line.

Approximete Interval Between Onset end Deeth

Immediate Cause (Final diseese or condition resulting in death): e. Hemorrhage — 2 days

Due to (or es e consequenca of): b. Gastrointestinal Bleed — 2 days

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

Due to (or es a consequenca of): c. Metastatic Cancer — 6 months

Due to (or es e consaquence of): d. multiple myeloma — 6 months

Pert II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residenca 6☐ Other *(Specify)*

27. Menner of Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To tha best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end menner steted.

29b. Signature end title of certifier: ▶ Curtis Harris MD

29c. License number: D53306

29d. Date signed *(Month, Dey, Year)*: 1/30/01

30. Nema and address of person who completed cause of deeth (Item 23a) (Type, Print): Curtis Harris MD 600 Ridgely Ave Ste 231 Annapolis MD 21401

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 30 2001

32. Registrer's Signetura: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

mcg

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04458

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Leo John Jakowski
2. Date of Death (Month, Day, Year): Jan. 26, 2001
3. Time of Death: 11:29 pm
4a. Facility Name (If not institution, give street and number): 1154 Little Magothy View
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 213-09-6859
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 89 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 15, 1911
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1154 Little Magothy View
10f. Zip Code: 21401
10g. Citizen of What Country?: USA
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Auto Worker
16b. Kind of Business/Industry: Automotive Manufacturer
17. Father's Name (First, Middle, Last): Ignac Jakowski
18. Mother's Name (First, Middle, Maiden Surname): Stella Szymanski
19a. Informant's Name/Relationship (Type, Print): Carol Ann Kiffer/Stepdaughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1152 Hampton Road Annapolis, MD 21401
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Rosary Cemetery
Date: Jan 30 2001
20c. Location - City or Town, State: Dundalk, Maryland
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home, 495 Gov. Ritchie Hwy. Severna Park, MD 21146

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Colon Cancer — 6 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes; Coronary artery disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D25499
29d. Date signed (Month, Day, Year): 1/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAMES Ruppel 180 Admiral Cochrane Dr Annapolis, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 04459

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BERNICE MARTINSON JONES
2. Date of Death Month Day Year: February 1, 2001
3. Time of Death: 11:30pm
4a. Facility Name *(If not institution, give street and number)*: William Hill Manor
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 352-01-7083
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 24 1918
9. Birthplace *(State or Foreign Country)*: Wisconsin

Usual Residence of Decedent

10a. State: MD
10b. County: Talbot
10c. City, Town or Location: Easton
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 501 Dutchman's Lane Apt. 112
10f. Zip Code: 21601
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 | College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: teacher
16b. Kind of Business/Industry: education

17. Father's Name *(First, Middle, Last)*: Charles Albert Martinson
18. Mother's Name *(First, Middle, Maiden Surname)*: Anne Lindquist

19a. Informant's Name/Relationship *(Type, Print)*: Richard D. Harrington-executor
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P. O. Box 253, Cambridge, MD 21613

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Salisbury Crematory
Date: 2-2
20c. Location - City or Town, State: Salisbury, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Thomas Funeral Home, PA
700 Locust St., Cambridge, MD 21613

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Cardio pulmonary Arrest	Seconds
Due to (or as a consequence of): b.	Acute Myocardial Infarction	3days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	AS/HD	10yrs
Due to (or as e consequence of): d.		

Part II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension Parkinsons Disease

23b. Did tobacco usa contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyelcian:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinlon, death occurred at the time, date and placa, and due to the cause(s) end manner steted.

29b. Signature and title of certifier: ▶ William Harold MD
29c. License number: D08715
29d. Date signed *(Month, Day, Year)*: 2/2/01

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): William H. Wood Jr., M.D. 505 Dutchmans Lane, Easton, MD 21601

State Registrar

31. Dete filed *(Month, Day, Year)*: FEB 02 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04460

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lois B. Kobernusz
2. Date of Death (Month, Day, Year): January 28, 2001
3. Time of Death: 1:45 pm
4a. Facility Name (If not institution, give street and number): Wilson Health Care Center
4b. City, Town, or Location of Death: Gaithersburg
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-01-5328
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 22 1911
9. Birthplace (State or Foreign Country): SD

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 201 Russell Avenue
10f. Zip Code: 20877
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse
16b. Kind of Business/Industry: Medical

17. Father's Name (First, Middle, Last): Harry Elmer Bolin
18. Mother's Name (First, Middle, Maiden Surname): Grace Elsie Hart

19a. Informant's Name/Relationship (Type, Print): Edward E. Kobernusz/ Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 333 Russell Avenue, Apt 322, Gaithersburg, MD 20877

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: January 29, 2001
20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: ▶ TRACY A. Stover
22. Name and Address of Facility: DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Artheroscleretic Heart Disease — Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Cerebravascular Disease; Hypertension

23b. Did **tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D 33357
29d. Date signed (Month, Day, Year): January 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lee Jonathan Musher MD, 5530 Wisconsin Avenue, Chevy Chase, MD 20815

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001
32. Registrar's Signature: ▶ [signature] G. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

b

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

12

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #2,2/9/2001,BMW,Montg.Co.

Certificate of Death

Reg. No. 2001 04461

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
JANET CAMBELL MACKENZIE KERN	January ~~17~~ 27, 2001	9:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
7420 Hampden Lane	Bethesda	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
054-12-9621	1☐ M 2☒ F	84 Yrs.			Dec. 7, 1916	Scotland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Bethesda	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7420 Hampden Lane	20814	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	3	Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Donald Mackenzie	Alice Murray

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Nathaniel Kern (Son)	5313 Albemarle Street; Bethesda, MD 20816

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Rock Creek Cemetery	02/1/01	Washington, DC

21. Signature of Funeral Service Licensee: W. Cathy Murray

22. Name and Address of Facility: JOSEPH GAWLER'S SONS, INC. 5130 Wisconsin Ave., NW; Washington, DC20016

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiopulmonary Arrest	5 minutes
Due to (or as a consequence of):	b. Hypertensive Cardiovascular Disease	10 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Lawrence Elliot Klein	MD14398	January 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lawrence E. Klein, M.D. 3301 New Mexico Ave., NW; Washington, DC 20016

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 02 2001	G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

b

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

20

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04462

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen Brett Kaye

2. Date of Death (Month, Day, Year): January 31, 2001

3. Time of Death: 6:25 a.m.

4a. Facility Name (If not institution, give street and number): The Casey House

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 085-09-0628

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 2, 1919

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 5225 Pooks Hill Road #305N

10f. Zip Code: 20815

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales

16b. Kind of Business/Industry: Jewelry

17. Father's Name (First, Middle, Last): (Unknown) Bretovsky

18. Mother's Neme (First, Middle, Maiden Surneme): Mary (Unknown)

19e. Informent's Name/Relationship (Type, Print): Andrea Kaye / Daughter

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1617 Avenue D, St. Leonard, Maryland 20685

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other pleca): Mt. Lebanon Cemetery

Date: Feb. 4, 2001

20c. Location - City or Town, State: Adelphi, Maryland

21. Signature of Funeral Service Licensee: Lauria A Heady

22. Name and Address of Facility: Rapp Funeral and Cremation Services, Stephen D. Lohrmann P.A. 933 Gist Ave., Silver Spring, MD. 20910

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Oral Cancer — Months

Due to (or es a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

b.

Due to (or as a consequenca of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco usa contribute to tha cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and piece, end due to the cause(s) and manner es stated.
2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: Stephen J. Newman

29c. License number: D15046

29d. Date signed (Month, Dey, Year): February 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Stephen J. Newman, M.D.; 19261 Montgomery Village Ave., Montgomery Village, MD. 20886

State Registrar

31. Date filed (Month, Dey, Year): FEB 02 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04463

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elsie L. Judkins
2. Date of Death (Month, Day, Year): January 31, 2001
3. Time of Death: 1:45 AM
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 224-07-1688
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 4, 1917
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 15400 Bassett Lane, Apt. 2A
10f. Zip Code: 20906
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Joseph C. Cassiter
18. Mother's Name (First, Middle, Maiden Surname): Druscilla Hicks

19a. Informant's Name/Relationship (Type, Print): Lawrence W. Judkins / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3317 Dunnington Road, Beltsville, Maryland 20705

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Peninsula Memorial Park | Date: 02/03/01
20c. Location - City or Town, State: Newport News, Virginia

21. Signature of Funeral Service Licensee: Richard Simms
22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. cerebrovascular accident — 24 Hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Acute Renal Failure

Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James A. Rossi, MD.
29c. License number: D 24593
29d. Date signed (Month, Day, Year): January 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James A. Rossi, MD 3305 N. Leisure World Blvd., Silver Spring MD 20906

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

6

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04464

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Harold David Johnson

2. Data of Death Month Day Year: January 25,2001

3. Time of Death: 6:30 PM

4a Facility Name (If not institution, giva street and number): LaPlata Nursing Center

4b. City, Town, or Location of Death: LaPlata

4c. County of Death: Charles County

Funeral Director

5. Social Security Number: 577-10-6940

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Yaar): Jan.1, 1911

9. Birthplaca (State or Foraign Country): Washington,DC

Usual Residence of Decedent

10a. Stata: Md.

10b. County: Charles

10c. City, Town or Location: Indian Head

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 3159 Jenkins Lane

10f. Zip Coda: 20640

10g. Citizan of What Country?: USA

11. Maritel Stetus: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decadant Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yes, Giva Yaar or Datas:

13. Was Dacedent of Hispanic Orlgin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Race - Americen Indien, Black, Whita, atc. Specify: white

15. Decedent's Eaucetion (Specify only highast grada completed): Elementery/Secondery (0-12): 12 | Collega (1-4or 5+):

16a. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired): Plumber

16b. Kind of Businass/Industry: H.D.Johnson,Inc.

17. Fathar's Nama (First, Middle, Last): John H. Johnson

18. Mother's Nama (First, Middle, Maidan Surname): Ida C. Burrows

19a. Informant's Name/Ralationship (Type, Print): John Johnson/Son

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): Rt.1 Box 150K Indian Head, MD 20640

20a. Mathod of Disposition: 1☒ Buriel 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Nama of cematary, cramatory or othar place): Gate of Heaven Cemetery

Data: Jan. 30, 2001

20c. Location - City or Town, Stata: SIlver Spring,Md.

21. Signature of Funeral Service Licensee: James E. DeVol

22. Nama end Address of Facility: DeVol Funeral Home 2222 Wisconsin Ave.,NW.,Washington,DC 20007

Physician /Medical Examiner

23a. Part I. Enter tha disaasa, or complicetions that caused tha daath. Do not enter tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart feilure. List only ona causa on aach lina.

Approximeta Intarval Between Onsat and Death

Immediata Causa (Final disaasa or condition rasulting in death)

a. Congestive Heart Failure

Dua to (or as a consequance of):

Sequantially list conditions, if any, laeding to immediata causa. Entar Undarlying Cause (Disease or injury that initiated events rasulting in death) Last

b. Dilated Cardiomyopathy

Dua to (or as a consequance of):

c.

Dua to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying ceuse given in Part I.

Prostate Carcinoma

Anemia

23b. Did tobacco uee contribute to the cauee of death? 1☐ Yee 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings availabla prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was cesa rafarred to medical examinar? 1☐ Yes 2☒ No

26. Place of Death (Check only ona) Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Othar (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29e. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, daath occurred at the time, data end place, end due to the cause(s) end manner es stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the tima, data and place, and dua to tha cause(s) end manner steted.

29b. Signetura end title of certifier: [illegible], MD

29c. License number: D 53885

29d. Date signed (Month, Day, Year): Jan. 26, 2001

30. Nama and addrass of person who completed cause of daath (Item 23a) (Type, Print): Venkat Ramanan,MD , 2041 Martin Luther King Jr.Avenue,SE.,Washington,DC 20020

State Registrar

31. Data filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signature: [illegible]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04465

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Janschek

2. Date of Death: Month Feb Day 1 Year 2001

3. Time of Death: 9pm

4a. Facility Name (If not institution, give street and number): Charles County Nrsg. Rehab center

4b. City, Town, or Location of Death: La Plata

4c. County of Death: Charles

Funeral Director

5. Social Security Number: 220-40-6493

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 15, 1912

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Charles

10c. City, Town or Location: Waldorf

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 3200 St. Peter's Church Road

10f. Zip Code: 20601

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Joseph Scheungrab

18. Mother's Name (First, Middle, Maiden Surname): Rose Schwingenschlagl

19a. Informant's Name/Reletionship (Type, Print): John J. Janschek - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6720 Maxwell Drive, Hughesville, MD 20637

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): St. Peter's Cemetery

Date: 2-5-01

20c. Location - City or Town, State: Waldorf, MD

21. Signature of Funeral Service Licensee: Mark G. Brohawn M00053

22. Name and Address of Facility: Huntt Funeral Home, Inc. P. O. Box 156, Waldorf, MD 20604-0156

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. CONGESTIVE HEART FAILURE — DAYS-YRS

Due to (or as a consequence of):

b. CARDIOVASCULAR DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

SEPSIS

(LT) FOOT INFECTION

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were eutopsy tindings available prior to completion of cause ot death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Streat and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the cause(s) and manner as steted. 2 ☐ **Medical Examiner**: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, date end ptece, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: [signature]

29c. Licanse number: D-44436

29d. Date signed (Month, Day, Year): FEB 02 2001

30. Nama and address of person who complated cause of death (Item 23a) (Type, Print): ASHVINKUMAR J PATEL 102 PAUL MILLER CT #102 WALDORF MD 20601

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001

32. Registrar's Signature: Penny G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04466

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Adele "Anne" Kenney

2. Date of Death: Month 02 Day 04 Year 2001

3. Time of Death: 8:40am

4a. Facility Name (If not institution, give street and number): Crofton Convalescent & Rehab. Center

4b. City, Town, or Location of Death: Crofton

4c. County of Death: Anne Arundle

Funeral Director

5. Social Security Number: 217-46-3676

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 5, 1915

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 707 Chesapeake Ave.

10f. Zip Code: 21403

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Office Assistant

16b. Kind of Business/Industry: MD State Income Tax Division

17. Father's Name (First, Middle, Last): Joseph F. Rodowsky

18. Mother's Name (First, Middle, Maiden Surname): Barbara A. Velenovsky

19a. Informant's Name/Relationship (Type, Print): William P. Kenney (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 707 Chesapeake Ave. Annapolis, MD 21403

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Most Holy Redeemer Cemetery

Date: 2/7/2001

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Brian J. Cyran

22. Name and Address of Facility: John M. Taylor Funeral Home, 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. Dementia — 5years

Due to (or as a consequence of): b. Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Howard K Schultz

29c. License number: 035848

29d. Date signed (Month, Day, Year): Feb. 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Howard K Schultz Jr. 1438 Defense Hwy Gambrills MD 21054

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001

32. Registrar's Signature: B Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND: #19a mcg 1/30/01 A.A.CO.HEALTH DEPT. *Certificate of Death*

Reg. No. 2001 04467

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Maria Kalivretenos

2. Date of Death (Month, Day, Year): January 27, 2001

3. Time of Death: 4:00 P.M.

4e. Facility Name (If not institution, give street and number): Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 193-26-3991

6. Sex: 1☐ M 2☒ F XX

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 10, 1924

9. Birthplace (State or Foreign Country): Ukraine

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Harwood

10d. Inside City Limits: 1☐ Yes 2☒ No XX

10e. Street and Number: 3635 Solomons Island Rd.

10f. Zip Code: 20776

10g. Citizen of What Country?: Ukraine

11. Marital Status: 1☐ Never Married 2☒ Married X 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No X If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No XX Specify:

14. Rece - Americen Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 7th

College (1-4or 5+):

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): (unknown)

18. Mother's Neme (First, Middle, Maiden Surname): (unknown)

19a. Informant's Name/Relationship (Type, Print): John A. ~~Kalivretenos~~ Kalivretenos / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3635 Solomons Island Rd. Harwood, Maryland 20776

20e. Method of Disposition: 1☒ Buriel X 2☐ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Demetrios Cemetery

Date: 1-31-01

20c. Location - City or Town, State: Annapolis, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037

To Be Completed by Funeral Director

mcg

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Respiratory failure — 2wks

Due to (or as a consequence of):

b. Chronic respiratory failure — 2years

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest

Due to (or es a consequence of):

c. Chronic obstructive Pulmonary disease — 10years

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

Valvular heart disease.
Chronic Atrial Fibrillation.
Coronary Athrosclerotic heart disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveileble prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) and manner es stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: DO8314

29d. Date signed (Month, Day, Year): 1/28/2001

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print): George C. SAMARAS MD 205 Ridgely Ave Annapolis, MD 21401

State Registrar

31. Dete filed (Month, Day, Year): JAN 30 2001

32. Registrer's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04468

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MaryAnne Lewis
2. Date of Death (Month, Day, Year): January 28, 2001
3. Time of Death: 8:00 PM
4a. Facility Name *(If not institution, give street and number)*: 264 Red Point Road
4b. City, Town, or Location of Death: North East
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 220-24-9803
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: October 1, 1929
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: North East
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 264 Red Point Road
10f. Zip Code: 21901
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Rural Route Carrier
16b. Kind of Business/Industry: United States Postal Service

17. Father's Name *(First, Middle, Last)*: Stephen Martin Phillip Dilks
18. Mother's Name *(First, Middle, Maiden Surname)*: Emma Rebecca Lockard

19a. Informant's Name/Relationship *(Type, Print)*: Robin Heath / Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 28 Rhode Island Avenue, Earleville, Maryland 21919

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Hart's Cemetery | Date: February 3, 2001
20c. Location - City or Town, State: Elk Neck, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Crouch Funeral Home, 127 South Main Street, North East, Maryland 21901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Carcinoma of lung with metastasis — about 10 mo

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.
29c. License number: D 44102
29d. Date signed *(Month, Day, Year)*: 1/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William F. Renzulli, MD, 901 Warburton Road, Elkton, Maryland 21921

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 31 2001
32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04469

Physician /Medical Examiner

1. Decedant's Name *(First, Middle, Last)*: Delia C. Lowman

2. Dete of Deeth: Month January Dey 29, Year 2001

3. Time of Death: 1:01 AM

4e. Facility Neme *(If not institution, give street end number)*: Frederick Memorial Hospital

4b. City, Town, or Location of Deeth: Frederick

4c. County of Deeth: Frederick

Funeral Director

5. Social Security Number: 578-62-1010

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. lest birthday)*: 92 Yrs.

If Under 1 Yeer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Year)*: Oct 7, 1908

9. Birthplace *(State or Foreign Country)*: Puerto Rico

Usuel Residence of Decedent

10a. Stete: DC

10b. County:

10c. City, Town or Location: Washington

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 4201 Cathedral Avenue NW Apt #623

10f. Zip Code: 20016

10g. Citizen of Whet Country?: USA

11. Merifal Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Giva Year or Dafes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☒ Yes 2☐ No *Specify:* Puerto Rican

14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedant's Educetion *(Specify only highest grade completed)*: Elementery/Secondary (0-12): ; College (1-4or 5+): 5+

16e. Decedant's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher

16b. Kind of Businass/Industry: Education

17. Fether's Name *(First, Middle, Last)*: Genaro Cardona Quinones

18. Mother's Name *(First, Middle, Maiden Surneme)*: Juana Maria Ortiz

19a. Informant's Name/Relationship *(Type, Print)*: Rick Lowman / Son

19b. Mailing Addrass *(Street end Number or Rural Route Number, City or Town, Stata, Zip Code)*: 9501 Bellhaven Court, Frederick, MD 21701

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Nema of cametary, cremetory or other place)*: Gate of Heaven Cemetery

Deta: Feb 1 2001

20c. Locetion - City or Town, Stete: Silver Spring, MD

21. Signeture of Funeral Service Licensee: Eric S. Acerbo

22. Neme end Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Pert I. Entar the disease, or complications thet ceusad tha deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failura. Llsf only one ceusa on aach lina.

Approximete Intervel Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in death)
e. Acute Myocardial Infarction — 1 hr.

Due to (or es a consequance of):

Sequentially list conditions, if eny, laeding to immediata ceuse. Enter Underlying Cause (Diseesa or Injury that initiatad events resulting in death) Lest
b.
Dua to (or as a consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other elgnificent conditions** contributing fo death but not rasulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to tha cauee of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Was en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior fo complation of ceuse of daeth? 1☐ Yes 2☒ No

25. Was cese refarred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding investigation 6☐ Could not be determined

28e. Data of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Descrlbe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Straat and Number or Rural Route Numbar, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyelcian:** To the best of my knowledga, daath occurred et the tima, data and place, and due to the cause(s) and mannar as statad. 2☐ **Medicaf Examinar:** On the basis of examinetion end/or investigation, In my opinion, death occurred et tha tima, data end place, end due to the ceusa(s) end mennar stated.

29b. Signeture and title of certifier: Robert L. Kaufmann

29c. License number: D-13971

29d. Date signed *(Month, Dey, Yeer)*: 1/31/01

30. Name end address of person who complated ceuse of death (Item 23a) (Type, Print): Robert L. Kaufmann, MD 300 West Ninth Street, Frederick, MD 21701

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 01 2001

32. Registrar's Signature: Barbara B. Sparks

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To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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GF

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04470

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Marie Ann Lewis
2. Date of Death Month: January Day: 25, Year: 2001
3. Time of Death: 12:45 PM
4e. Facility Name *(If not institution, give street and number)*: Mariner Health Care at Circle Manor
4b. City, Town, or Location of Death: Kensington
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 546-24-4150
8. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 90 Yrs.
If Under 1 Yeer: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov. 29, 1910
9. Birthplace *(State or Foreign Country)*: Iowa

Usual Residance of Decedant

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Wheaton
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 12068 Milton Street
10f. Zip Coda: 20902
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Giva Yaer or Detas:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Maxican, Puerto Rican, atc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elamantary/Secondary (0-12): 12; Collega (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT usa retired)*: Cook
16b. Kind of Business/Industry: Mental Health Institute

17. Fathar's Nama *(First, Middla, Last)*: Joseph Miller
18. Mothar's Name *(First, Middle, Maiden Sumama)*: Sophia Wollman

19a. Informant's Name/Relationship *(Type, Print)*: David J. Christian/Grandson
19b. Mailing Addrass *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 631 Marcia Lane, Rockville, Maryland 20851

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Nama of cemetery, crematory or othar placa)*: Gate of Heaven Cemetery
Data: Jan 30 2001
20c. Location - City or Town, Stata: Silver Spring, Maryland

21. Signatura of Funeral Service Licensee: [signature] M00198
22. Name end Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ona causa on aach lina.

Approximata Intarval Between Onset and Death

Immediata Cause (Final disaasa or condition rasulting in daath)
a. Myocardial Infarction — Sudden
Dua to (or as a consequance of):
Sequentially tist conditions, if any, laading to immadiata cause. Enter Underlying Cause (Diseasa or Injury that initiated events resulting in death) Last
b.
Dua to (or as a consequence of):
c.
Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying ceusa given in Part I.: Congestive Heart Failure; Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was cesa rafarred to medicel examiner? 1☐ Yes 2☒ No

26. Placa of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Cartifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha time, data and place, and due to tha cause(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at the time, date and place, and dua to tha ceuse(s) and mannar stated.

29b. Signatura and title of cartifier: [signature] MD
29c. Licansa number: D53528
29d. Data signed *(Month, Day, Year)*: January 26, 2001

30. Name and addrass of person who completed cause of daath (Item 23a) (Type, Print): Daphna Henkin, M.D. 2309 Shorefield Road, Wheaton, Maryland 20902

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 30 2001
32. Registrar's Signatura: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04471

Amend #23a,c,1/31/2001,BMW,Montg.Co.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Yiu Fai Leung	January 22, 2001	3:42 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Montgomery General Hospital	Olney	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
227-39-5230	1☒M 2☐F	79 Yrs.			Nov. 19, 1921	China

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Rockville	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4522 Muncaster Mill Road	20853	China

11. Marital Status	12. Was Decedent Evar in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, atc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Yaar or Dates:	1☐Yes 2☒No Specify:	Specify: Asian

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Businass/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6		Sales Representative	Martial Arts Supplies

17. Father's Name (First, Middle, Last)	18. Mother's Nama (First, Middle, Maiden Sumame)
Wong Leung	Sau Hing Cheung

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Winnie H. Leung / Daughter	4522 Muncaster Mill Road, Rockville, Maryland 20853

20a. Method of Disposition	20b. Place of Disposition (Nama of cametery, crematory or othar place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from Stata 4☐Donation 5☐Other (Specify)	Gate of Heaven Cemetery	01/27/01	Silver Spring, Maryland

21. Signature of Funaral Service Licensee: Dana Achtarb

22. Nama and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused tha daath. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock or haart failura. List only ona causa on aach lina.

		Approximate Intarval Batwaan Onset and Daath
Immediate Cause (Final disease or condition rasulting in death)	a. Acute Respiratory Distress Syndrome	17 days
Due to (or as a consequence of):	b. Aspiration Pneumonia	17 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaasa or Injury that initiated events resulting in death) Last	c. ~~Poly substance overdose~~	17 days
Due to (or as a consequenca of):	d.	

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Wara autopsy findings available prior to completion of causa of daath? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Placa of Death (Check only one): Hospital 1☒Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residance 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicida 5☐Panding investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, offica building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2☐**Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, daath occurred at the time, data and place, and due to tha causa(s) and mannar statad.

29b. Signature and title of certifier: David B. Mallard MD

29c. License number: D51908

29d. Date signed (Month, Day, Year): January 22 2001

30. Name and address of person who completed cause of daath (Item 23a) (Type, Print): David B. Mallard MD Suite 327 Prince Philip Drive Olney Maryland

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04472

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lillian Leopold

2. Data of Death Month: 01 Day: 30 Yaar: 2001

3. Tima of Death: 1:00 pm

4a. Facility Neme (If not institution, give street and number): Summerville of Potomac 11215 Seven Locks Rd.

4b. City, Town, or Location of Deeth: Potomac

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 143-38-5717

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): NOV. 4, 1914

9. Birthplaca (Stata or Foraign Country): NEW JERSEY

Usual Residence of Decedent

10a. Stata: MD

10b. County: ST. MARY'S

10c. City, Town or Location: LEXINGTON PARK

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 46271 CECIL RD.

10f. Zip Coda: 20653

10g. Citizen of What Country?: U.S.A.

11. Maritaf Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Giva Yaar or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yes 2☒ No Specify:

14. Race - Amarican Indian, Black, Whita, etc. Specify: WHITE

15. Decedent's Education (Specify only highast grade compiated): Elementary/Secondary (0-12): 12 | Collega (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Businass/Industry: OWN HOME

17. Fathar's Nama (First, Middla, Last): BENJAMIN SEMEL

18. Mothar's Nama (First, Middla, Maiden Sumame): GUSSIE HERMAN

19a. Informant's Name/Relationship (Type, Print): MARTIN LEONARD LEOPOLD/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 46271 CECIL RD. LEXINGTON PARK, MD 20653

20a. Mathod of Disposition: 1☐ Burial 2☐ Cremetion 3☒ Removal from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Placa of Disposition (Nama of cematery, crematory or othar placa): BETH ISRAEL CEMETERY

Data: FEB. 1, 2001

20c. Location - City or Town, Stata: WOODBRIDGE, NJ

21. Signature of Funaral Service Licensee ▶

22. Nama and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20854

Physician /Medical Examiner

23a. Part1. Enter the diseasa, or complications that causad tha daath. Do not enter tha moda of dying, such as cardiac or respiratory arrast, shock, or heart failura. List only one cause on each line.

Approximata Intarval Batwaen Onset and Death

Immediata Causa (Final diseasa or condition rasulting in death)

a. MYOCARDIAL INFARCTION — 10 MINS

Dua to (or as a consequenca of):

b. HYPERTENSION — 20 YRS

Sequentiafly list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last

Dua to (or as a consequance of):

c. HYPERLIPIDEMIA — 50 YRS

Dua to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the undarlying cause givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Were autopsy findings available prior to complation of causa of death? 1☐ Yes 2☐ No

25. Was casa rafarrad to medical examiner? 1☐ Yas 2☑ No

26. Placa of Daath (Chack only ona)

Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA

Othar: 4☐ Nursing Homa 5☐ Residence 6☑ Other (Specify) ASSISTED LIVING

27. Mannar of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Date of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify)

28f. Location (Straat and Number or Rural Routa Numbar, City or Town, Stata)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowladga, daath occurred at tha tima, data and placa, and dua to tha cause(s) and mannar as statad. 2☐ **Medical Examiner:** On tha basis of examination and/or invastigation, in my opinion, death occurred at tha time, date and placa, and dua to tha causa(s) and manner statad.

29b. Signature and title of certifier ▶ Sangeetha Murthy

29c. Licansa number: D0055200

29d. Data signad (Month, Day, Year): JANUARY 30 2001

30. Name and address of person who complated causa of death (Item 23a) (Type, Print): SANGEETHA MURTHY 11119 ROCKVILLE PIKE, SUITE 401, ROCKVILLE 20852

State Registrar

31. Data filed (Month, Day, Year): FEB 02 2001

32. Registrar's Signature ▶ Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

6

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04473

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HELEN ANKENEY LEET

2. Data of Death Month Day Yaar: JANUARY 31, 2001

3. Tima of Death: 1:45 PM

4a Facility Neme (If not institution, giva street and number): SHADY GROVE NURSING & REHABILITATION CENTER

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Deeth: MONTGOMERY

Funeral Director

5. Social Security Number: 272-10-2911

6. Sax: 1☐ M 2☒ F

7. Aga (In yrs. last birthday): 84 Yrs.

If Under 1 Yaar: Months / Days

If Undar 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): Jan 13, 1917

9. Birthpleca (State or Foreign Country): Ohio

Usual Residence of Dacedant

10a. Stata: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 125 Central Avenue

10f. Zip Code: 20877

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedant Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Giva Yaar or Datas:

13. Was Decedant of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Rece - Amarican Indian, Black, White, etc. Specify: White

15. Decedant's Education (Specify only highast grada compliated)

Elementary/Secondery (0-12):

Collaga (1-4or 5+): 3

16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Fathar's Nama (First, Middle, Last): Harry Ankeney

18. Mothar's Nama (First, Middle, Meidan Sumama): Lottie Martindale

19a. Informent's Name/Ralationship (Type, Print): Bruce Leet, Son

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 14500 Cartwright Way, Gaithersburg, MD 20878

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Piece of Disposition (Neme of cemetery, cramatory or othar place): Metropolitan Crematory

Date: Feb 2, 2001

20c. Location - City or Town, Stata: Alexandria, Virginia

21. Signature of Funaral Service Licensee:

22. Nama and Addrass of Facility: DeVol Funeral Home 10 E. Deer Park Drive, Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part I. Entar tha diseasa, or complications that caused the death. Do not anter tha mode of dying, such as cardiac or respiretory arrast, shock, or haart failure. List only one cause on aech line.

Approximata Interval Batwean Onsat and Daath

Immediata Ceuse (Finel disease or condition resulting in daath)

a. CONGESTIVE HEART FAILURE — 6 MONTHS

Due to (or as a consequanca of):

Sequantially list conditions, if any, laading to immadiata causa. Enter Undarlying Ceuse (Diseasa or injury that initiated evants resulting in death) Last

b. CORONARY ARTERY DISEASE — 6 MONTHS

Dua to (or as a consequenca of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying cause givan in Part I.

STROKE

DEMENTIA

23b. Did tobacco uae contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were eutopsy findings availabla prior to complation of cause of daath? 1☐ Yas 2☐ No

25. Was case refarred to medical examiner? 1☐ Yes 2☒ No

26. Placa of Daath (Check only one)

Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA

Othar: 4☒ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Cartifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowladga, daath occurred at tha time, data and piece, and due to tha causa(s) and mannar as statad. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the tima, date and placa, and due to tha cause(s) and mannar stated.

29b. Signatura and tita of certifiar:

29c. Licansa number: D28656

29d. Date signad (Month, Day, Year): February 2, 2001

30. Nama and address of person who complated causa of daath (Item 23a) (Type, Print): Ravi Passi, M.D., 15225 Shady Grove Road, Rockville, Maryland 20850

State Registrar

31. Dete filed (Month, Day, Year): FEB 02 2001

32. Registrar's Signature: Penny B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04474

Physician /Medical Examiner

1. Decedent's Nama *(First, Middle, Last)*: Harry Montgomery Leet

2. Data of Death Month / Day / Yaar: January 27, 2001

3. Time of Death: 11:40pm

4e Facility Nema *(If not institution, giva street end number)*: SHady Grove Adventist Hospital

4b. City, Town, or Location of Deeth: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 277-12-6010

6. Sex: 1☒ M 2☐ F

7. Aga *(In yrs. last birthday)*: 84 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Aug. 24, 1916

9. Birthplaca *(Steta or Foraign Country)*: Tennessee

Usual Rasidance of Dacedant

10e. Stete: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 125 Central Avenue

10f. Zip Coda: 20877

10g. Citizan of What Country?: United States

11. Marital Status: 1☐ Navar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1☒ Yas 2☐ No If Yas, Giva Yaar or Datas: WWII

13. Wes Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxicen, Puarto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Amaricen Indian, Black, Whita, etc. *Specify:* White

15. Decedant's Education *(Specify only highest grade complated)*: Elementary/Secondary (0-12) | Collega (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT usa retired)*: Lawyer

16b. Kind of Businass/Industry: Legal

17. Fethar's Nema *(First, Middla, Last)*: Harry Ward Leet

18. Mothar's Name *(First, Middle, Maiden Surnema)*: Betty Montgomery

19a. Informant's Name/Relationship *(Type, Print)*: Helen Ankeney Leet/ Wife

19b. Mailing Address *(Street end Number or Rural Routa Number, City or Town, Steta, Zip Coda)*: 125 Central Avenue, Gaithersburg, MD 20877

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cemetery, crematory or othar place)*: Metropolitan Crematory

Data: January 30, 2001

20c. Location - City or Town, Stata: Alexandria, Virginia

21. Signature of Funaral Service Licensee: ▶ Tracy A Stover

22. Nama and Address of Facility: DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part1. Enter the diseasa, or complications that ceusad tha daath. Do not enter tha moda of dying, such as cerdiac or raspiratory arrast, shock, or haart failura. List only one cause on aach line.

Approximate Intarval Batween Onset and Death

Immediata Causa (Final diseasa or condition rasulting in daath)

a. Acute Myocardial Infarction — Minutes

Dua to (or as a consequance of):

Sequantially list conditions, if any, laading to immadiata ceuse. Entar Underlying Cause (Disease or injury that initiated evants rasulting in death) Last

b.

Dua to (or as a consequance of):

c.

Dua to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying ceusa given in Part I.

23b. Did tobacco uae contribute to the cauae of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of ceusa of death? 1☐ Yas 2☒ No

25. Wes case referred to medical examinar? 1☐ Yes 2☒ No

26. Placa of Deeth *(Chack only one)*: Hospital: 1☐ Inpatiant 2☒ ER/Outpatient 3☐ DOA | Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined

28a. Dete of Injury *(Month, Dey Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stete)*

29e. Cartifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledge, daath occurred at tha tima, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigetion, in my opinion, death occurred at tha tima, date and place, and dua to tha causa(s) and mannar stated.

29b. Signatura and title of certifier: ▶ Deborah Sherrill MD

29c. Licanse number: D36979

29d. Date signed *(Month, Day, Year)*: January 28, 2001

30. Nama and address of person who completed ceuse of daath (Item 23a) (Type, Print): Deborah J. Sherrill, M.D. 4901 Medical Center Drive, Rockville, MD 20850

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 31 2001

32. Registrar's Signatura: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

20 (10)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 04475

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Kyung Cha Lee
2. Deta of Deeth — Month: January Dey: 27 Year: 2001
3. Time of Death: 11:55 AM
4e Facility Nema *(If not institution, give street end number)*: Suburban Hospital
4b. City, Town, or Location of Deeth: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Sociel Security Number: 578-02-3668
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 63 Yrs.
If Under 1 Year — Months: Deys:
If Under 24 Hrs. — Hours: Min.:
8. Date of Birth *(Month, Day, Year)*: July 15, 1937
9. Birthplace *(State or Foraign Country)*: Korea

Usuel Residence of Decedent

10e. Stete: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 12510 Veirs Mill Road, Apt. 201
10f. Zip Code: 20853
10g. Citizen of Whet Country?: USA
11. Merital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Raca - Amarican Indian, Bleck, White, etc. *Specify:* Asian
15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home
17. Fethar's Neme *(First, Middle, Last)*: Heung Soon Kim
18. Mother's Name *(First, Middle, Maiden Surneme)*: Sun Jeon Im
19a. Informent's Neme/Reletionship *(Type, Print)*: William Lee / Husband
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 12510 Veirs Mill Road, Apt. 201, Rockville, MD 20853
20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Placa of Disposition *(Neme of cemetery, crematory or other placa)*: George Washington Cem.
Date: 01/30/01
20c. Location - City or Town, State: Adelphi, Maryland
21. Signature of Funeral Service Licensee: James Schwartz
22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

6

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disaase or condition resulting in deeth)
a. Cardio-pulmonary collapse — 10 min.
Due to (or es e consequence of):
b. Cerebral infarction, right hemisphere — 6 days
Due to (or es a consequenca of):
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Last
c. Cerebral aneurysm, right middle cerebral — 7 days
Due to (or es e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Deeth *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Plece of Injury - At home, ferm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner steted.

29b. Signature and title of certifier: Donald C. Wright, MD
29c. License number: 54327
29d. Date signed *(Month, Dey, Year)*: January 27, 2001

30. Name and addrass of person who completed cause of deeth (Item 23a) (Type, Print): Donald C. Wright, M.D. 3 Washington Circle, N.W., #306, Washington, DC 20037

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

State Registrar

31. Deta filed *(Month, Dey, Year)*: JAN 31 2001
32. Registrer's Signetura: Bruce G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #23a, 2/6/2001, GF, Montg.Co.

Certificate of Death

Reg. No. 2001 04476

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Andrew David Lautman

2. Date of Death: Month: January; Day: 26; Year: 2001

3. Time of Death: 12:05AM

4a. Facility Name (If not institution, give street and number): Casey House

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-74-8138

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 48 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 4, 1952

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3507 Woodridge Aveune

10f. Zip Code: 20902

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Architectural

16b. Kind of Business/Industry: Photography

17. Father's Name (First, Middle, Last): Robert C. Lautman

18. Mother's Name (First, Middle, Maiden Surname): Corinne Pressman

19a. Informant's Name/Relationship (Type, Print): Pamela P. Lautman / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3507 Woodridge Ave., Silver Spring, MD 20902

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Chesapeake Crematory

Date: Jan. 31, 2001

20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Kevin A. Hardy

22. Name and Address of Facility: Rapp Funeral And Cremation Services 933 Gist Aveune Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Amyotrophic Lateral Sclerosis — ~~13~~ 28 mo.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Aylesworth

29c. License number: D0054375

29d. Date signed (Month, Day, Year): 1/2c/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Cheryl Aylesworth M.D. 6900 Georgia Aveune NW, Washington, DC

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04477

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ina C. Lassberg
2. Date of Death: Month January Day 31 Year 2001
3. Time of Death: 8:15 P.M.
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 220-44-9295
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 22, 1918
9. Birthplace (State or Foreign Country): Kentucky

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 15310 Pine Orchard Drive, #1-J
10f. Zip Code: 20906
10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: World War II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): - College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Registered Nurse
16b. Kind of Business/Industry: Hospital

17. Father's Name (First, Middle, Last): Bernard Kegan
18. Mother's Name (First, Middle, Maiden Surname): Mary Hand

19a. Informant's Name/Relationship (Type, Print): Terrye Gamage/ Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18 Farsta Court, Rockville, Maryland 20850

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc.
Date: February 3, 2001
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: [signature] M00689
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. CEREBROVASCULAR ACCIDENT — 8 HOURS

Due to (or as a consequence of):
b. ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE — UNKNOWN

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D24543
29d. Date signed (Month, Day, Year): February 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James A Agosti, MD 3305 N. Leisure World Blvd., Silver Spring MD 20906

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signature: [signature] D. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #16a, 16b., 2.8/2001, GF, Montg.Co. *Certificate of Death* Reg. No. 2001 04478

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Edward Joseph Lachowicz
2. Date of Death Month Day Year: January 28, 2001
3. Time of Death: 12:08 PM
4a. Facility Name *(If not institution, give street and number)*: Laurel Regional Hospital
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 185-12-8666
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 77 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov. 15, 1923
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: Adelphi
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9816 26th Avenue
10f. Zip Code: 20783
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: ~~Arbitrator~~ International Representative
16b. Kind of Business/Industry: ~~Railroad~~ IBEW

17. Father's Name *(First, Middle, Last)*: Joseph Lachowicz
18. Mother's Name *(First, Middle, Maiden Surname)*: Louisa Fabian

19a. Informant's Name/Relationship *(Type, Print)*: Ruth Lachowicz / Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9816 26th Avenue, Adelphi, Maryland 20783

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Fort Lincoln Cemetery
Date: 02/02/01
20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis — 1 day

Due to (or as a consequence of):
b. Pneumonia — 1 day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus
Arteriosclerotic Cardiovascular Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] M.D.
29c. License number: D24721
29d. Date signed *(Month, Day, Year)*: January 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Syed A. Sadiq, M.D. 14333 Laurel Bowie Road, Laurel, Maryland 20708

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 02 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-0476-015
mnmr
Kathleen V. Lanigan

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04479

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kathleen Virginia Lanigan
2. Date of Death (Month, Day, Year): January 28, 2001
3. Time of Death: 1537 pm
4a. Facility Name (If not institution, give street and number): Route 222 and New Bridge Road
4b. City, Town, or Location of Death: Rising Sun
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 030-70-5542
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 17 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 8, 1983
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Port Deposit
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 22 Sage Court
10f. Zip Code: 21904
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yes 2☒ No Specify:
14. Race - Amaricen Indian, Black, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa ratired): Student
16b. Kind of Business/Industry: Public School

17. Fathar's Name (First, Middle, Last): John B. Lanigan
18. Mother's Name (First, Middle, Maiden Sumame): Judith A. Speers

19a. Informent's Name/Relationship (Type, Print): John & Judy Lanigan
19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 22 Sage Court, Port Deposit, MD 21904

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal trom State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): West Nottingham Cemetery | Date: 2-1-01
20c. Location - City or Town, State: Colora, Maryland

21. Signature of Funeral Sarvice Licensee:
22. Name and Address of Facility: R. T. Foard Funeral Home, P. A. 111 S. Queen St., Rising Sun, MD 21911

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet ceusad the death. Do not enter the mode ot dying, such as cerdiac or respiratory arrest, shock, or heart teilure. List only one cause on eech line. | Approximate Interval Between Onset and Death

Immediate Cause (Finet disease or condition resulting in death): a. MULTIPLE INJURIES
Due to (or as a consequence of):
Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings aveileble prior to completion of ceuse of death? 1☒ Yes 2☐ No

25. Was cese rafarrad to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) at scene

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year): 1/28/01
28b. Time of Injury: 1526 M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: DRIVER OF CAR WHICH WAS STRUCK BY ANOTHER VEHICLE
28e. Place of Injury - At homa, farm, straat, factory, offica building, etc. (Specify): ROADWAY
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete): RT 222 AND NEWBRIDGE ROAD, RISINGSUN, MD

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as steted. 2☒ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: [signature] M.D.
29c. License number: O.C.M.E.
29d. Data signed (Month, Dey, Year): January 29, 2001

30. Nama and address of person who completed ceuse of death (Item 23a) (Type, Print): MARLY G. RIPPLE M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Year): JAN 31 2001
32. Registrar's Signature: [signature] D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 04480

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Evelyn Anderson Mote

2. Date of Death Month Dey Yeer: January 27, 2001

3. Time of Death: 12:30 p.m.

4a. Facility Name *(If not institution, give street and number)*: Montgomery General Hospital

4b. City, Town, or Location of Death: Olney

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 523-03-9499

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: Nov. 23, 1916

9. Birthplace *(State or Foreign Country)*: Colorado

Usual Residence of Decedent

10e. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 14805 Pennfield Circle

10f. Zip Code: 20906

10g. Citizen of Whet Country?: United States

11. Maritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Edcetion *(Specify only highest grede completed)*: Elementery/Secondary (0-12) / College (1-4or 5+): 1

16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Neme *(First, Middle, Last)*: Joseph Francis Anderson

18. Mother's Neme *(First, Middle, Maiden Surneme)*: Blanche Markle

19a. Informent's Name/Relationship *(Type, Print)*: Lynn Mote/ Husband

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, State, Zip Code)*: 14805 Pennfield Circle, Silver Spring, Md. 20906

20e. Method of Disposition: 1☐ Buriel 2☒ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Chesapeake Crematory Inc.

Dete: Jan. 31, 2001

20c. Location - City or Town, Stete: Beltsville, Maryland

21. Signature of Funeral Service Licensee: Dennis A. Hardy

22. Name end Address of Feclity: Rapp Funeral and Cremation Services, Stephen D. Lohrmann P.A. 933 Gist Ave., Silver Spring, Md. 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert failure. List only one cause on each line.

Approximete Interval Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in death): e. Acute Myocardial Infarction — hour

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last:

b. Coronary arteriosclerosis — years

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significent conditions** contributing to deeth but not resulting in the underlying ceuse given in Part I.

23b. Did tobecco use contribute to the cause of deeth? 1☐ Yes 2☐ No 3☐ Probebly 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was cese referred to medicel examiner? 1☒ Yes 2☐ No

26. Piece of Death *(Check only one)*: Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☒ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medicel Exeminer:** On the besis of exemination end/or investigation, in my opinion, deeth occurred et the time, date and plece, end due to the ceuse(s) end menner steted.

29b. Signature and title of certifier: Alan Spealman MD

29c. License number: D0025827

29d. Dete signed *(Month, Dey, Yeer)*: January 29, 2001

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): Alan Spealman, MD 18101 Prince Philip Dr Olney, Maryland 20832

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: FEB 02 2001

32. Registrer's Signature: Penny B. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04481

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John A. McLaine
2. Date of Death (Month, Day, Year): January 20, 2001
3. Time of Death: 4:05 PM
4a. Facility Name *(If not institution, give street and number)*: Shady Grove Adventist Hospital
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 363-16-1331
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 91 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 12, 1909
9. Birthplace *(State or Foreign Country)*: Michigan

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 9305 Wescott Place
10f. Zip Code: 20850
10g. Citizen of What Country?: USA

11. Meritel Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Rece - American Indien, Black, White, etc. *Specify:* USA

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12) / College (1-4or 5+): 5
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Engineer
16b. Kind of Business/Industry: Automotive

17. Father's Neme *(First, Middle, Last)*: James McLaine
18. Mother's Name *(First, Middle, Maiden Sumeme)*: Edith Graves

19a. Informent's Neme/Reletionship *(Type, Print)*: Margaret McLaine (Wife)
19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 9305 Wescott Place Rockville, MD 20850

20a. Method of Disposition: 1 [ ] Buriel 2 [X] Cremetion 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Othar *(Specify)*
20b. Piace of Disposition *(Neme of cemetery, cremetory or othar piece)*: Metropolitan Crematory — Date: 1/21/01
20c. Location - City or Town, Stete: Alexandria, VA

21. Signeture of Funerel Service Licensee: Allen L. Woodall
22. Name end Address of Fecility: Hysong Company 1300 N. Street NW Washington, DC 20005

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset and Death

Immediete Cause (Final diseese or condition resulting in death)
e. Aspiration Pneumonia — 5 Days

Due to (or es e consequence of):
b. Left Hip Fracture, Due to Fall — 10 Days

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last
Due to (or es e consequence of):
c. Osteoporosis

Due to (or es e consequence of):
d.

Jan M Poffenroth DME 1/29/01

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings eveilable prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Wes cese referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Deeth *(Check only one)*: Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Menner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner es stated. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the ceuse(s) end menner steted.
29b. Signeture end title of certifier: MD.
29c. License number: D56652
29d. Date signed *(Month, Day, Year)*: JANUARY 29, 2001

30. Neme and eddress of person who completed ceuse of death (Item 23a) (Type, Print): Matthew Poffenroth, MD 809 Viers Mill Road Rockville, MD

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 30 2001
32. Registrer's Signeture: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04482

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward J. McGlynn
2. Data of Death — Month: January Day: 29, Year: 2001
3. Time of Death: 12:48 am
4a. Facility Name (If not institution, give street and number): Wilson Health Care Center
4b. City, Town, or Location of Death: Gaithersburg
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 124-07-8688
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): April 22, 1919
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 301 Russell Avenue
10f. Zip Code: 20877
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates: WWII Korea
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor
16b. Kind of Business/Industry: Customs

17. Father's Name (First, Middle, Last): Daniel McGlynn
18. Mother's Name (First, Middle, Maiden Surname): Katherine McGlynn

19a. Informant's Name/Relationship (Type, Print): Gerald K. Gimmel, Pers. Rep.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4 Professional Drive, Gaithersburg, MD 20877

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, cremetory or other place): Metropolitan Crematory
Data: Feb 3, 2001
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: ▶ Gary M. Sisi
22. Name and Address of Facility: DeVol Funeral Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive heart failure
Due to (or as a consequence of):
b. Ischemic cardiomyopathy

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Atrial fibrillation
Recent amputation (above knee) right leg
Emphysema
Peripheral vascular disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ H. Robert Birschbach M.D.
29c. License number: D04115
29d. Data signed (Month, Day, Year): January 29, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): H. Robert Birschbach, M.D., 6320 Democracy Blvd., Bethesda, Maryland 20817

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signature: ▶ Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

6

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04483

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Herbert K. McGinty
2. Date of Death Month Day Year: January 29, 2001
3. Time of Death: 2:35 PM
4a. Facility Name *(If not institution, give street and number)*: Wilson Health Care Center
4b. City, Town, or Location of Death: Gaithersburg
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-60-4487
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 87 Yrs. If Under 1 Yaar: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: December 16, 1913
9. Birthplace *(State or Foreign Country)*: Oklahoma

Usual Residence of Decedant

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1 [X] Yas 2 [ ] No
10e. Street and Number: 415 Russell Avenue #815
10f. Zip Code: 20877
10g. Citizen of What Country?: United States
11. Marital Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1 [ ] Yas 2 [X] No If Yes, Giva Year or Dates:
13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No *Specify:*
14. Raca - Amarican Indian, Black, Whita, atc. *Specify:* White
15. Decedent's Education *(Specify only highast grada completed)*: Elamantary/Secondary (0-12); Collega (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work dona during most of working lifa. DO NOT use retired)*: Accountant
16b. Kind of Businass/Industry: Federal Government
17. Fathar's Name *(First, Middla, Last)*: Kendrick H. McGinty
18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Amile Jones
19a. Informant's Name/Ralationship *(Type, Print)*: Linda M. Scott/ Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5408 Waneta Road Bethesda, Maryland 20816
20a. Mathod of Disposition: 1 [ ] Burial 2 [X] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar *(Specify)*
20b. Place of Disposition *(Nama of cematary, cramatory or othar place)*: Montgomery Crematorium Inc.
Data: January 30, 2001
20c. Location - City or Town, Stata: Bethesda, Maryland
21. Signature of Funaral Service Licensee: [signature] M00335
22. Nama and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused tha daath. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or haart tailura. List only one ceusa on aach line.

Approximate Interval Between Onset and Death

Immediate Causa (Finel disaasa or condition rasulting in death)
e. Congestive Heart Failure — 2 Days
Dua to (or as a consaquanca of):
b. Ischemic Cardiomyopathy
Due to (or as a consequanca of):
c. Coronary Artery Disease
Dua to (or as a consequance of):
d.

Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

Chronic Obstructive Pulmonary Disease

Cronhn's Disease

Gastroenteritis

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Wara autopsy findings available prior to complation of cause of daath? 1 [ ] Yas 2 [ ] No

25. Was case referrad to medical axaminar? 1 [ ] Yas 2 [X] No

26. Place of Death *(Check only ona)*: Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatiant 3 [ ] DOA; Othar: 4 [X] Nursing Homa 5 [ ] Rasidanca 6 [ ] Othar *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Pending invastigation 6 [ ] Could not be determined

28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Dascribe how injury occurred
28e. Placa of Injury - At homa, farm, straat, factory, offica building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To tha best of my knowledga, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On tha basis of examination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to the cause(s) and mannar stated.

29b. Signatura and title of certifier: [signature]
29c. Licansa number: D 04115
29d. Data signed *(Month, Day, Year)*: January 29, 2001

30. Nama and address of person who complatad causa of daath (Item 23a) (Type/Print): H. Robert Birschbach, 6320 Democracy Boulevard Bethesda, Maryland 20817

State Registrar

31. Data filed *(Month, Day, Year)*: FEB 02 2001
32. Registrar's Signatura: [signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04484

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Julia D. McDowell
2. Date of Death: Month January, Dey 30, Year 2001
3. Time of Death: 12:35 AM
4a. Facility Name (If not institution, giva street and number): Casey House
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 221-12-9802
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): June 25, 1923
9. Birthplece (State or Foreign Country): PA.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 9312 Edgewood Drive
10f. Zip Code: 20877
10g. Citizen of Whal Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Educelion (Specify only highast grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Antique Dealer
16b. Kind of Business/Industry: Antiques

17. Father's Name (First, Middle, Last): William Dudkewitz
18. Mother's Name (First, Middle, Maiden Surname): Julia Sypa

19a. Informant's Name/Relationship (Type, Print): Samuel C.T. McDowell/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 9312 Edgewood Drive, Gaithersburg, MD. 20877

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Forest Oak Cemetery
Date: 2/3/01
20c. Localion - City or Town, State: Gaithersburg, MD.

21. Signature of Funeral Service Licensee: Michael A. Shuller
22. Name and Address of Facility: DeVol Funeral Home, 10 East Deer Park Dr., Gaithersburg, MD. 20877

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the deeth. Do not enler the mode of dying, such as cerdiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. Chronic Obstructive Pulmonary Disease — Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseasa or injury that initiated events resulting in deeth) Lest:
b.
Due lo (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing lo deeth but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the csuse of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yas 2☒ No
24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yas 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA; Other: 4☐ Nursing Home 5☐ Rasidance 6☒ Other (Specify) Hospice

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and place, and due to the ceuse(s) end menner es steted.
2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Joseph Kaplan M.D.
29c. License number: D 35635
29d. Date signed (Month, Day, Year): January 30, 2001

30. Nama and addrass of person who completed ceuse of death (Item 23a) (Type, Print): Joseph Kaplan, M.D., 18111 Prince Philip Drive, Olney, Maryland 20832

State Registrar

31. Date filed (Month, Dey, Year): FEB 02 2001
32. Registrar's Signature: Bruce G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04485

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert L. McCormick, Sr.

2. Date of Death (Month, Day, Year): January 30, 2001

3. Time of Death: 7:47 AM

4a. Facility Name *(If not institution, give street end number)*: Montgomery General Hospital

4b. City, Town, or Location of Death: Olney

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 222-10-7944

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: February 2, 1923

9. Birthplace *(State or Foreign Country)*: Delaware

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street end Number: 3636 Edelmar Terrace

10f. Zip Code: 20906

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Area Operations Officer

16b. Kind of Business/Industry: CIA

17. Father's Name *(First, Middle, Last)*: Frank H. McCormick

18. Mother's Name *(First, Middle, Maiden Surname)*: Marguerite Beyea

19a. Informant's Name/Relationship *(Type, Print)*: Robert L. McCormick, Jr./ Son

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 14123 Bauer Drive Rockville, Maryland 20853

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Montgomery Crematorium Inc.

Date: January 31, 2001

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: [signature] M00335

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION — IMMEDIATE

Due to (or as a consequence of):

b. ARTERIOSCLEROTIC HEART DISEASE — 5 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, In my opinion, death occurred et the time, date end piece, end due to the cause(s) and manner stated.

29b. Signature end title of certifier: [signature] James A Rossi MD

29c. License number: D24593

29d. Date signed *(Month, Day, Year)*: January 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAMES A. ROSSI, MD 3305 N. LEISURE WORLD BLVD. SILVER SPRING MD 20906

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 01 2001

32. Registrar's Signature: [signature] G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

GF

20 + 1

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #29d, 2/6/2001, GF, Mont.Co.

Certificate of Death

Reg. No. 2001 04486

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DAVID F. MARTIN

2. Date of Death — Month: JANUARY Day: 30 Year: 2001

3. Time of Death: 07:55 AM

4a. Facility Name (If not institution, give street and number): MONTGOMERY GENERAL HOSPITAL

4b. City, Town, or Location of Death: OLNEY

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 220-26-2582

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Jan. 17 1921

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedant

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Laytonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7404 Rocky Road

10f. Zip Code: 20882

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Farmer

16b. Kind of Business/Industry: Dairy Farming

17. Father's Name (First, Middle, Last): Oscar C. Martin

18. Mother's Name (First, Middle, Maiden Surname): Barbara Beuchert

19a. Informant's Name/Relationship (Type, Print): Harriet W. Martin / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7404 Rocky Road, Laytonsville, Maryland 20882

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Salem Cemetery

Data: 2/2/01

20c. Location - City or Town, State: Brookeville, Md.

21. Signature of Funeral Service Licensee: Muriel H. Barber

22. Name and Address of Facility: Muriel H. Barber Funeral Home, P. O. Box 5038, Laytonsville, Md. 20882

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

GF

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. PNEUMONIA — 2 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

OBSTRUCTIVE LUNG DISEASE, Diabetes Mellitus, RENAL INSUFFICIENCY

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one) — Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

8+1 (8)

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Frank J. Mayo, MD

29c. License number: D23630

29d. Date signed (Month, Day, Year): January 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Frank J. Mayo, MD 16220 Frederick Rd #213 Gaithersburg, MD 20877

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001

32. Registrar's Signature: Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04487

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARGARET ANN MARSHALL
2. Date of Death (Month, Day, Year): JANUARY 26, 2001
3. Time of Death: 10:30 AM
4a. Facility Name *(If not institution, give street and number)*: 21912 GOSHEN SCHOOL ROAD
4b. City, Town, or Location of Death: GAITHERSBURG
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 153 24 2577
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JUNE 7, 1933
9. Birthplace *(State or Foreign Country)*: NEW JERSEY

Usual Residence of Decedent

10a. State: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: GAITHERSBURG
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 21912 GOSHEN SCHOOL ROAD
10f. Zip Code: 20882
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: MICHAEL DAVERN
18. Mother's Name *(First, Middle, Maiden Surname)*: MARGARET DRESSING

19a. Informant's Name/Relationship *(Type, Print)*: ROBERT K. MARSHALL, HUSBAND
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 21912 GOSHEN SCHOOL ROAD, GAITHERSBURG, MD. 20882

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ARLINGTON NAT'L. CEMETERY | Date: 1/31/01
20c. Location - City or Town, State: ARLINGTON, VIRGINIA

21. Signature of Funeral Service Licensee: ▶ Muriel H. Barber
22. Name and Address of Facility: MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Esophagal Cancer	One Year
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ MD
29c. License number: 033686
29d. Date signed *(Month, Day, Year)*: JANUARY 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kenneth M.W. MD 18111 Prince Philip Dr. Olney MD 20832

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 29 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04488

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John E. Maloni
2. Date of Death (Month, Day, Year): January 31, 2001
3. Time of Death: 1:47 am
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 205-18-2472
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 88 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)
8. Date of Birth (Month, Day, Year): Dec 27, 1912
9. Birthplace (State or Foreign Country): Italy

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 15100 Interlachen Drive #802
10f. Zip Code: 20906
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yaar or Datas: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): School Teacher
16b. Kind of Business/Industry: Montgomery County Public Schools

17. Father's Name (First, Middle, Last): Paul J. Maloni
18. Mother's Name (First, Middle, Maiden Surname): Rosa Pistilli

19a. Informant's Name/Relationship (Type, Print): Paul J. Maloni/ Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2706 Hunter's Gate Terrace, Silver Spring, MD 20904

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery
Date: Feb 3 2001
20c. Location - City or Town, State: Silver Spring,MD

21. Signature of Funeral Service Licensee: Andrew J. Cole
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode ot dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Acute Myocardial Infarction	2 days
Due to (or as a consequenca of): b.	Chronic Congestive Cardiomyopathy	years
Sequentially list conditions, if any, teading to immediate cause. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequenca of): c.	Coronary Artery Disease	years
Due to (or as a consequenca of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa givan in Part I.

Congestive Heart Failure, mitral regurgitation

Aortic Insufficiency, old myocardial infarctions

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical axaminer? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residenca 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner es steted. 2 [ ] **Medical Examiner**: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and piaca, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Roger F. Leonard
29c. Licansa number: D28791
29d. Date signed (Month, Day, Year): February 2, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Roger F. Leonard, MD 6116 Executive Blvd., Rockville, MD 20852

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04489

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mohammad Rafiq MAlik

2. Date of Death Month: January Day: 28 Year: 2001

3. Time of Death: 1325

4a. Facility Name (If not institution, give street and number): Shady Grove Adventist Hospital

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 218-37-3339

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 59 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug 13, 1941

9. Birthplace (State or Foreign Country): Pakistan

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: GERMANTOWN

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 20229 Redbuckeye Ct.

10f. Zip Code: 20876

10g. Citizen of What Country: Pakistan

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Asian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Unemployed

16b. Kind of Business/Industry: NoNe

17. Father's Name (First, Middle, Last): Mohammad Amin Malik

18. Mother's Name (First, Middle, Maiden Surname): Bakhtar Begum

19a. Informant's Name/Relationship (Type, Print): Mohammad Waheed Malik-Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 20229 Redbuckeye Ct, Germantown, Md. 20876

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): George Wash Cemet.

Date: 1-29-2001

20c. Location - City or Town, State: Adelphi, Maryland

21. Signature of Funeral Service Licensee: Dane de Mateo

22. Name and Address of Facility: Universal II Mortuary Inc. 411 Kennedy St, N.W., Wash, D.C.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction — 3 hour

Due to (or as a consequence of):

b. Hypertension — 5 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Diabetes Mellitus — 2 year.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Panding investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es steted. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: MD

29c. License number: D42222

29d. Date signed (Month, Day, Year): January 28th 2001

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Mukhtar Chandy 11119 Rockville Pike Rockville MD 20878.

State Registrar

31. Date filed (Month, Day, Year): JAN 30 2001

32. Registrer's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

GF

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04490

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruby A. Madron
2. Date of Death (Month, Day, Year): January 29, 2001
3. Time of Death: 2:41 pm
4a. Facility Name (If not institution, give street and number): 792 Hopewell Road
4b. City, Town, or Location of Death: Rising Sun
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 220-14-0876
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 10, 1925
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Rising Sun
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 792 Hopewell Road
10f. Zip Code: 21911
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurses Aide
16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): David Eastridge
18. Mother's Name (First, Middle, Maiden Surname): Alma Lockey Roten

19a. Informant's Name/Relationship (Type, Print): Pauline Rogers/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1123 New York Ave., West Chester, PA 19380

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Brookview Cemetery
Date: 2-2-01
20c. Location - City or Town, State: Rising Sun, Maryland

21. Signature of Funeral Service Licensee: Richard L. Goodie
22. Name and Address of Facility: R. T. Foard Funeral Home, P. A. 111 S. Queen St., Rising Sun, MD 21911

Physician /Medical Examiner

25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. myocardial infarction — 5min

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic obstructive pulmonary disease; obstructive sleep apnea

23b. **Did tobacco use contribute to the cause of death?** 1☒ **Yes** 2☐ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joshua N. Aaron MD
29c. License number: D0047471
29d. Date signed (Month, Day, Year): January 30th, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Joshua N. Aaron MD Suite 101 111 W. High St Elkton MD

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001
32. Registrar's Signature: Jeanne B. Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04491

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alma Elizabeth McMichael
2. Date of Death: Month January Day 28 Year 2001
3. Time of Death: 1815 P
4a. Facility Name (If not institution, give street and number): Union Hospital
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 222-44-1336
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN 28, 1913
9. Birthplace (State or Foreign Country): Delaware

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Delaware
10b. County: New Castle
10c. City, Town or Location: Wilmington
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 28 Lee Drive
10f. Zip Code: 19808
10g. Citizen of What Country?: United States
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner/Landlord
16b. Kind of Business/Industry: Real Estate
17. Father's Name (First, Middle, Last): Sumner Jones
18. Mother's Name (First, Middle, Maiden Surname): Amanda White
19a. Informant's Name/Relationship (Type, Print): Mildred Hubbard/Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 28 Lee Drive, Wilmington, Delaware 19808
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Riverview Cemetery
Date: 2/2/01
20c. Location - City or Town, State: Wilmington, Delaware
21. Signature of Funeral Service Licensee: Donald S. Hicks
22. Name and Address of Facility: Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921

Physician /Medical Examiner

rgw

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respratary Failure
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Obstructive Sleep Apnea
Due to (or as a consequence of):
c. pneumonia
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
obesity, hypothyroidism, dementia, schizoaffective d/o, pulmonary hypertension.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residance 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Christine E.K. Horah, D.O.
29c. License number: H00054380
29d. Date signed (Month, Day, Year): 01/29/01.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Christine E.K. Horah, D.O 412 Suburban Plaza, Newark DE 19711

8

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04492

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lester B. McMillan
2. Date of Death (Month, Day, Year): January 31, 2001
3. Time of Death: 12:30 p.m.

4a. Facility Name (If not institution, give street and number): 2698 North East Road
4b. City, Town, or Location of Death: North East
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 218-14-9174
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar. 2, 1924
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: North East
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2698 North East Rd.
10f. Zip Code: 21901
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Builder
16b. Kind of Business/Industry: Construction

17. Fether's Name (First, Middle, Last): James H. McMillan
18. Mother's Name (First, Middle, Maiden Surname): Rebecca Ann Smith

19a. Informant's Name/Relationship (Type, Print): Christine Smith/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2698 North East Rd., North East, MD 21901

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): West Nottingham Cemetery
Date: 2-5-01
20c. Location - City or Town, State: Colora, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: R. T. Foard Funeral Home, P. A. 111 S. Queen St., Rising Sun, MD 21911

Physician /Medical Examiner

rgw

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Chronic Obstructive Pulmonary Disease (COPD.)	> 2yrs.
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or es e consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Malnutrition

23b. Did tobacco use contribute to the causs of death? 1 [ ] Yss 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy tindings aveilable prior to completion of cause ot death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: [signature] MD
29c. License number: D 32609
29d. Date signed (Month, Day, Year): 2/1/01

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Kamnadin Mithani MD 1106 Revolution Ct Havre de Grace MD 21078

State Registrar

31. Dete filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

25

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

AMEND#28A PERGP 2/1/01 AACO Health Dept

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04493

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Richard Selwyn Morgan

2. Date of Death (Month, Day, Year): 01 22 2001

3. Time of Death: 12:40 PM

4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 057 07 6770

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 15 1918

9. Birthplace (State or Foreign Country): Great Britain

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Arnold

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 703 Rusack Court

10f. Zip Code: 21012

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No. If Yes, Give Year or Dates: 1942-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Planning and Policy Officer

16b. Kind of Business/Industry: US Government

17. Father's Name (First, Middle, Last): Thomas Morgan

18. Mother's Name (First, Middle, Maiden Surname): Blodwen Owen

19a. Informant's Name/Relationship (Type, Print): Stephen L. Morgan/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 703 Rusack Court, Arnold MD 21012

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory

Date: 1/24/01

20c. Location - City or Town, State: Alexandria VA

21. Signature of Funeral Service Licensee: ▶ Mathilma Wagon

22. Name and Address of Facility: Advent Funeral and Cremation Services Annapolis MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

b. End Stage Parkinsons

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year): N/A

28b. Time of Injury: M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶

29c. License number: D39037

29d. Date signed (Month, Day, Year): 1/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DS MITCHELL, ANNE ARUNDEL MEDICAL CENTER, ANNAPOLIS MD

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001

32. Registrar's Signature: ▶ Donna P Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04494

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John J. McCarthy
2. Date of Death (Month, Day, Year): Feb. 3, 2001
3. Time of Death: 1:20 am
4a. Facility Name *(If not institution, give street and number)*: Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 577-36-2548
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 72 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug. 13, 1928
9. Birthplace *(State or Foreign Country)*: IL

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Severna Park
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 740 McCann Road
10f. Zip Code: 21146
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): ; College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Cryptologist
16b. Kind of Business/Industry: Federal Government

17. Father's Name *(First, Middle, Last)*: Clarence McCarthy
18. Mother's Name *(First, Middle, Maiden Surname)*: Evelyn Gooch

19a. Informant's Name/Relationship *(Type, Print)*: Angelica McCarthy/Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 740 McCann Road, Severna Park, MD 21146

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory
Date: Feb 5, 2001
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: James E. Barranco
22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park, MD 21146 495 Gov. Ritchie Hwy, Severna Park, MD 21146

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiogenic Shock
Due to (or as a consequence of):
b. End Stage Cardiomyopathy
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. Ischemic Heart disease
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☒ No
26. Piece of Deeth *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: Elizabeth M. Kingsley MD
29c. License number: D22507
29d. Date signed *(Month, Day, Year)*: 02/04/2001

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print): Elizabeth M. Kingsley, MD 2003 Medical Parkway, Annapolis, MD 21401

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 05 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04495

Myers, Alice Kds

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Alice Marie Myers

2. Date of Death: Month 01 Day 31 Year 2001

3. Time of Death: 2150

4e. Facility Name *(If not institution, give street and number)*: Dorchester General Hospital

4b. City, Town, or Location of Death: Cambridge

4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 579-18-7986

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 14 1915

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Dorchester

10c. City, Town or Location: Cambridge

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 818 Locust St.

10f. Zip Code: 21613

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9 / College (1-4 or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: sales clerk

16b. Kind of Business/Industry: drug store

17. Father's Name *(First, Middle, Last)*: Lewis Wesley Jenkins

18. Mother's Name *(First, Middle, Maiden Surname)*: Virginia Elizabeth Mooney

19a. Informant's Name/Relationship *(Type, Print)*: Donna M. Willey - daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 818 Locust St., Cambridge, MD 21613

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Dorchester Memorial Park

Date: 2-4

20c. Location - City or Town, State: Cambridge, Maryland

21. Signature of Funeral Service Licensee: John T Thomas

22. Name and Address of Facility: Thomas Funeral Home, PA
700 Locust St., Cambridge, MD 21613

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Peritonitis

Due to (or as a consequence of):
b. Perforated Diverticuli

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Timothy J. Snieszek MD

29c. License number: D53253

29d. Date signed *(Month, Day, Year)*: 2/2/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Timothy J. Snieszek
503-A Muir St Cambridge, MD 21613

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 02 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04496

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Rupert Randolph Murphy Jr.

2. Dete of Death — Month: JAN Dey: 31 Year: 2001

3. Time of Death: 0600

4e. Feciity Neme (If not institution, give street and number): 309 Noble St.

4b. City, Town, or Location of Death: Hurlock

4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 216-38-8236

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 59 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Year): January 22 1942

9. Birthplace (State or Foreign Country): Maryland

Usuel Residence of Decedent

10a. State: MD

10b. County: Dorchester

10c. City, Town or Location: Hurlock

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 309 Noble St.

10f. Zip Code: 21643

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Raca - American Indien, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 / College (1-4or 5+):

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): electrician

16b. Kind of Business/Industry: chemical company

17. Fether's Neme (First, Middle, Last): Rupert E. Murphy Sr.

18. Mother's Neme (First, Middle, Maiden Surneme): Louise Brohawn

19e. Informent's Neme/Relationship (Type, Print): Frances Murphy - wife

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): P. O. Box 614, Hurlock, MD 21643

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Unity-Washington

Dete: 2-3

20c. Location - City or Town, State: Hurlock, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Feciity: Thomas Funeral Home, PA 700 Locust St., Cambridge, MD 21613

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset end Death

Immediate Ceuse (Finel disease or condition resulting in deeth)
e. Cardiac Arrhythmia — 4 min

Due to (or as e consequenca of):
b. Coronary Artery Disease — 5 yrs

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Last

Due to (or as a consequenca of):
c. Congestive Heart Failure — 5 hrs

Due to (or es a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Rectal Carcinoma

23b. Did tobecco use contribute to the cauee of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Phyeicien:** To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) and menner es steted. 2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, dete end placa, end due to the ceuse(s) and menner stated.

29b. Signeture and title of certifier: ▶ [signature] MD

29c. License number: D26358

29d. Date signed (Month, Day, Year): JAN 31, 2001

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): Michael Packham MD 302 Collins Ave Hurlock Md 21643

State Registrar

31. Dete filed (Month, Dey, Yeer): FEB 02 2001

32. Registrer's Signeture: Denise G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760, **To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04497

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marian V. Norton

2. Data of Daath: Month 01 Day 30 Yaar 2001

3. Tima of Death: 1940

4a Facility Nama (If not institution, giva street and number): University & Maryland Medical System

4b. City, Town, or Location of Daath: Baltimore

4c. County of Death: none

Funeral Director

5. Social Security Number: 577-40-4543

6. Sax: 1☐ M 2☒ F

7. Aga (In yrs. last birthday): 71 Yrs.

If Undar 1 Yaer: Months / Days

If Undar 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Yaar): Feb.28,1929

9. Birthplaca (Stata or Foraign Country): Maryland

Usual Rasidance of Decadant

10a. Stata: Maryland

10b. County: Prince George's

10c. City, Town or Location: Greenbelt

10d. Insida City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 7764 Lakecrest Drive

10f. Zip Code: 20770

10g. Citizan of What Country?: United States

11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decadant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decadant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxicen, Puarto Rican, atc.) 1☐ Yes 2☒ No Specify:

14. Race - Amaricen Indian, Black, White, etc. Specify: White

15. Decadant's Educetion (Specify only highast grada compliatad): Elamentary/Secondary (0-12): 12; Collega (1-4or 5+):

16a. Decadant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): Secretary

16b. Kind of Businass/Industry: private

17. Father's Nama (First, Middla, Last): George C. Yates

18. Mothar's Nama (First, Middla, Maidan Sumama): Lillian E. Herbert

19a. Informant's Name/Ralationship (Type, Print): Eugene C. Norton - Husband

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): same as #10a - 10g

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donetion 5☐ Othar (Specify)

20b. Place of Disposition (Nama of cematary, cramatory or othar place): Metropolitan Crematory

Data: 2/2/2001

20c. Location - City or Town, Stata: Alexandria, Virginia

21. Signature of Funaral Service Licensee: ▶ Donald V Borgwardt

22. Name and Addrass of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that ceused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batwaan Onsat and Death

Immediata Causa (Final diseasa or condition rasulting in death)

a. Sepsis — 50 days

Dua to (or as a consequance of):

b. Multi System organ Failure — 50 days

Saquantially list conditions, if any, laading to immadiata ceuse. Entar Undarlying Cause (Disaase or injury that initiated evants rasulting in death) Last

Dua to (or as a consequanca of):

c. — 5

Dua to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying ceusa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings aveilabla prior to compliation of ceusa of death? 1☐ Yas 2☒ No

25. Wes casa rafarrad to medical examiner? 1☐ Yas 2☒ No

26. Placa of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Yaar)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one) 1☒ **Certifying Physician**: To tha best of my knowledga, daath occurrad at tha tima, data and place, and dua to tha ceusa(s) and mannar as stated. 2☐ **Medical Examiner**: On the basis of examination and/or invastigation, in my opinion, daath occurrad at tha tima, data and place, and dua to the ceusa(s) and mannar stated.

29b. Signature and title of cartifiar: ▶ [signature]

29c. Licansa number: 12458

29d. Data signad (Month, Day, Yaar): 1/30/2001

30. Nama and addrass of parson who complatad causa of daath (Item 23a) (Type, Print): Cory Clossen MD, University & Maryland Medical System, Baltimore, MD 21201

State Registrar

31. Data filad (Month, Day, Yaar): FEB 01 2001

32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04498

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Elizabeth Noland
2. Date of Death (Month, Day, Year): Jan. 27, 2001
3. Time of Death: 7:46 P.M.

4a. Facility Name (If not institution, give street and number): Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 564-27-0316
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 12, 1924
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6813 Fairfax Road
10f. Zip Code: 20814
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Hiram Eckert
18. Mother's Name (First, Middle, Maiden Surname): Katie Faust

19a. Informant's Name/Relationship (Type, Print): Mary Mella Abernathy - Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4718 River Road Bethesda, MD 20816

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): National Crematory
Date: 2/2/01
20c. Location - City or Town, State: Falls Church, VA

21. Signature of Funeral Service Licensee: Thomas E. Hombaker
22. Name and Address of Facility: Joseph Gawler's Sons 5130 WI Ave. N.W. Washington, D.C. 20016

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac Arrhythmia
Due to (or as a consequence of):
b. Hypodycemia
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. Diabetes mellitus — Years
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Osteoarthritis
Legally Blind

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: E. P. Libre M.D.
29c. License number: D 09470
29d. Date signed (Month, Day, Year): January 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Eugene Libre, M. D. 10400 Connecticut Ave. #606 Kensington, MD 20895

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020
Division of Vital Records, P.O. Box 68760,

NOLAND, MARY E 1-27-01 1946

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04199

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death (Month, Day, Year)	3. Time of Death
Esther	Perlmuter	Jan. 29, 2001	9:15P.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Hebrew Home of Greater Washington	Rockville	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
022-10-6952	1☐ M 2☒ F	95 Yrs.			July15,1905	Massachusetts

Usual Residance of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Rockville	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Coda	10g. Citizan of What Country?
6121 Montrose Road	20852	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yas, Give Year or Datas:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grada completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	Collaga (1-4or 5+)		
12	2	Owner	Childrens Clothing

17. Father's Nama (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Meyer Perlmuter	Eva unk

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda)
Elizabeth Perlmuter - sister	3315 Wisconsin Avenue, N.W. Washington, D.C. 20016

20a. Method of Disposition	20b. Place of Disposition (Name of cematary, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Lawrence Avenue Cemetery	2/1/01	Boston, Massachusetts

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part I. Enter tha disease, or complications that causad tha daath. Do not anter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

		Approximata Interval Batween Onsat and Death
Immediate Causa (Final disease or condition resulting in daath)	a. ASPIRATION PNEUMONIA	
	Dua to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Causa (Diseese or injury that initiated events resulting in death) Last	b. VASCULAR DEMENTIA	
	Due to (or as a consequance of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to daath but not resulting in the underlying cause givan in Part I.

23b. Did tobacco use contribute to the cauae of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referad to medical examiner?	26. Place of Death (Check only ona)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Rasidance 6☐ Other (Specify)

27. Mannar of Death	28a. Date of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Describa how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify)			28f. Location (Straet and Number or Rural Route Number, City or Town, State)

29a. Cartifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurred at the tima, data and place, and due to the causa(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at the tima, data and place, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] M.D.	D 18084	JANUARY 30,2001

30. Name and address of parson who completed causa of daath (Item 23a) (Type, Print): D.D. PATEL M.D. 6121 Montrose Rd, Rockville, MD 20852

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 01 2001	[signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

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Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 04500

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Joseph Patrick Parlon
2. Date of Death Month Day Year: January 27, 2001
3. Time of Death: 5:25 PM
4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-62-1636
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 94 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sep. 19, 1906
9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Kensington
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10231 Carroll Place
10f. Zip Code: 20895
10g. Citizen of Whet Country?: USA

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Printing
16b. Kind of Business/Industry: Federal Government
17. Father's Neme *(First, Middle, Last)*: Joseph Patrick Parlon
18. Mother's Name *(First, Middle, Maiden Surneme)*: Katherine Driey
19a. Informent's Neme/Reletionship *(Type, Print)*: Patricia C. Parlon/Daughter-in-law
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 13123 Beaver Terr., Rockville, Maryland 20853
20a. Method of Disposition: 1☒ Burlel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other place)*: Mount Olivet Cemetery — Date: 02/01/01
20c. Location - City or Town, State: Washington, DC
21. Signeture of Funerel Service Licensee: Anthony S. DeMary
22. Neme end Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line. — Approximete Intervel Between Onset end Death

Immediete Ceuse (Finel diseese or condition resulting in death)
a. Pneumonia
Due to (or es e consequence of):
Sequentielly list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Lest
b.
Due to (or es e consequenca of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Coronary artery disease
Chronic obstructive pulmonary disease

23b. Did tobacco uas contribute to ths causs of death? 1☒ Yss 2☐ No 3☐ Probably 4☐ Unknown
24a. Wes en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings eveileble prior to completion of cause of death? 1☐ Yes 2☒ No
25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Piece of Death *(Check only one)*: Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exemineticn and/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner steted.
29b. Signeture end title of certifier: PHYSICIAN
29c. License number: 100545 66
29d. Dete signed *(Month, Dey, Yeer)*: January 28, 2001
30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print): S. Bhogavilli, M.D. 10907 Amherst Ave., #323, Silver Spring, Maryland 20902

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JAN 31 2001
32. Registrer's Signeture: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

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